EXHIBIT 20

In The Matter Of:

TERRY LYNN KING vs

TONY PARKER, et al.

VIDEOTAPED VIDEOCONFERENCE DEPOSITION OF PHYSICIAN

October 12, 2021

Gibson Court Reporting

606 West Main Street

Suite 350

Knoxville, TN 37902

Gibson COURT REPORTING

Min-U-Script®

VIDEOTAPED VIDEOCONFERENCE DEPOSITION OF PHYSICIAN

October 12, 2021

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

TERRY LYNN KING,	)	
	)	
Plaintiff,	)	CAPITAL CASE
	)	
vs.	)	CASE NO.
	)	3:18-CV-01234
TONY PARKER, et al.,	)	
	)	
Defendants.	)	

APPEARANCES:

FOR THE PLAINTIFF:

ALEX KURSMAN, ESQ.
LYNNE LEONARD, ESQ.
ANA BALDRIGE, ESQ.
HAYDEN NELSON-MAJOR, ESQ.
Assistant Federal Defenders
Federal Community Defender Office
for the Eastern District of Pennsylvania
601 Walnut Street, Suite 545W
Philadelphia, Pennsylvania 19106

JEREMY GUNN, ESQ.
Bass, Berry & Sims PLC
150 Third Avenue South, Suite 2800
Nashville, Tennessee 37201

SCOTT C. SUTHERLAND, ESQ.
DEAN S. ATYIA, ESQ.
CODY N. BRANDON, ESQ.
Tennessee Attorney General's Office
P.O. Box 20207
Nashville, Tennessee 37202

ALSO PRESENT: David Jenkins, Videographer
Jules Welsh, Esq.

S T I P U L A T I O N S

The videotaped videoconference deposition of PHYSICIAN, called as a witness at the instance of the Plaintiff, taken pursuant to all rules applicable to the Federal Rules of Civil Procedure by notice on the 12th day of October, 2021, at 10:00 a.m., before Rhonda S. Sansom, RPR, CRR, CRC, Licensed Court Reporter, pursuant to stipulation of counsel.

It being agreed that Rhonda S. Sansom, RPR, CRR, CRC, Licensed Court Reporter, may report the deposition in machine shorthand, afterwards reducing the same to typewriting.

All objections except as to the form of the questions are reserved to on or before the hearing.

It being further agreed that all formalities as to notice, caption, certificate, transmission, et cetera, including the reading of the completed deposition by the witness and the signature of the witness, are expressly waived.

I N D E X

E X A M I N A T I O N S

PHYSICIAN	PAGE
Examination by Ms. Nelson-Major	6

E X H I B I T S

No.	Description	Page
80	Agreement Between the Tennessee Department of Correction and [Redacted] re Provider Bates Ds' First Resp. to RFP 000170-171	28

THE VIDEOGRAPHER: We're on the record at 10:00 a.m. Eastern Standard Time on October 12th, 2021.

This is the video deposition of Physician taken remotely via Zoom in the matter of Terry Lynn King versus Tony Parker, et al., Case No. 3:18-CV-01234, filed in the U.S. District Court, Middle District of Tennessee, Nashville Division.

Counsel will state their names and affiliations for the record, and the court reporter will swear in the witness.

MS. NELSON-MAJOR: Good morning. My name is Hayden Nelson-Major. I'm with the Federal Community Defender Office for the Eastern District of Pennsylvania. I represent the plaintiff in this matter, Terry King.

Also on the Zoom today from my office is Lynne Leonard, Ana Baldrige, and Alex Kursman.

Also from my office is Jules Welsh, a new attorney with our office who is not representing Mr. King but is just joining to observe today for educational purposes.

And lastly, also representing Terry King is Jeremy Gunn with Bass, Berry & Sims.

MR. SUTHERLAND: Good morning. Scott

Sutherland with the Tennessee Attorney General's Office. We represent the defendants in the case, Commissioner Tony Parker and Warden Tony Mays.

And we also represent the Physician here for the purposes of this deposition.

Also present on the record are Dean Atyia and Cody Brandon with our office.

And I think that's it, Ms. Nelson-Major, other than I assume we're going with the standing process of objection to form. We will reserve all objections as we have in our other depositions, except objections based on privilege.

MS. NELSON-MAJOR: Yes, that's fine by me.

MR. SUTHERLAND: All right. And ready when you are.

THE COURT REPORTER: At this time, I'll place our witness under oath.

(Technical pause.)

THE WITNESS: I've lost audio.

MR. SUTHERLAND: Are you able to hear?

THE WITNESS: Yes.

MR. SUTHERLAND: You can hear.

PHYSICIAN,

having been first duly sworn, testified as follows:

(Discuss off the record.)

THE VIDEOGRAPHER: We're back on record at 10:06 a.m.

EXAMINATION

BY MS. NELSON-MAJOR:

Q. Good morning, Physician. As I said, my name is Hayden Nelson-Major. I'm an attorney with the Federal Community Defender Office located in Philadelphia, Pennsylvania. I represent Terry King, the plaintiff in this matter of King versus Parker currently pending in the Middle District of Tennessee.

Thank you for taking the time to answer these questions today.

You understand you're here today to answer questions related to the King case, right?

A. Yes.

Q. What is your understanding of what that case is about?

A. I'm not sure if I know.

Q. I would like to cover a couple of ground rules before we get started. Have you ever had your deposition taken before?

A. Yes.

Q. How many times?

A. Two or three.

Q. And when did those depositions occur?
A. Over the past 40 years.
Q. And when was the most recent deposition?
A. Guesstimating, 2006.
Q. And what were those cases about?
MR. SUTHERLAND: I'm going to -- Ms. Nelson-Major, I'm going to have -- instruct the Physician to be very general in his description of the cases.
So you can give a general description of the cases. And my instructions are based on the Court's protective order.
BY MS. NELSON-MAJOR:
Q. You can go ahead and answer, Physician.
A. In some cases, there was a complication from treatment rendered. In other cases, I testified for the plaintiff.
Q. Were they medical malpractice cases?
A. Yes.
Q. Were you the defendant in any of those cases?
A. Yes.
Q. And in how many of those two or three cases were you the defendant?
A. Two.

Q. And what were the outcome of those two cases?
A. I didn't go to trial. We settled out of court.
Q. Physician, I'm having a hard time hearing that. Could you repeat your answer, please?
A. Settled out of court.
Q. Did both of the cases settle out of court?
A. Yes.
Q. And was the plaintiff awarded monetary damages?
A. I assume.
Q. I'm sorry, did you say "I assume?"
MS. NELSON-MAJOR: Rhonda, are you having a hard time hearing the Physician's answers?
(Discussion off the record.)
MR. KURSMAN: This is Alex Kursman. Can we go off the record again?
THE VIDEOGRAPHER: We are off the record.
(Discussion off the record.)
THE VIDEOGRAPHER: We are back on record at 10:14 a.m.
BY MS. NELSON-MAJOR:
Q. The two medical malpractice cases that

settled out of court, did either one involve issues related to the setting of IV lines?

A. No.

Q. Did either involve issues related to determining a patient's consciousness?

A. No.

Q. And did either involve issues related to pronouncing death?

A. No.

Q. Have you ever been deposed about your role in executions conducted by Tennessee?

A. No.

Q. And do you understand that you're under oath today?

A. Yes.

Q. Is there any reason you cannot testify truthfully or accurately today?

A. No.

Q. And are you represented by counsel?

A. Not personally.

Q. And even though this deposition is being taken over Zoom, the court reporter is making a record based on what you say. If you don't understand a question, just let me know and I'll try my best to clarify the question. However, if you answer a

question I will assume you understood.

If you need to take a break at any time, let me know. I'll just ask that you answer any pending questions before we take a break.

Mr. Sutherland may object to my questions from time to time, but you will need to answer unless the objection is based on an assertion of privilege.

Is there anyone else in the room with you today?

A. No.

Q. What did you do to prepare for the deposition today?

A. Reviewed some documents and had a meeting with the Attorney General's Office.

Q. And when did you have that meeting with people from the Attorney General's Office?

A. Within the last two months.

Q. Was it just one meeting?

A. Possibly two.

Q. And who was present at those meetings from the Attorney General's Office?

A. Rob Mitchell and Scott Sutherland come to mind, along with others.

Q. And were all the other people present also with the Attorney General's Office?

A. As far as I know, yes.
Q. And how long did those meetings last?
A. 20 to 30 minutes.
Q. And what documents did you review?
A. A contract, the protocol. That's all that I recall.
Q. Did Mr. Mitchell and Mr. Sutherland provide you with those documents?
A. I had the contract, and the protocol was reviewed via Zoom.
Q. Did you review any other materials to prepare for the deposition today?
A. Could you repeat your question?
Q. Did you review any other documents in preparation for today's deposition?
A. The Hippocratic Oath.
Q. And why did you review the Hippocratic Oath?
A. In case there were any questions pertaining to it.
Q. Did you meet with anyone else other than personnel from the Attorney General's Office in preparation for today?
A. No.
Q. Did you review transcripts from any of

the other depositions taken in this case?
A. No.
Q. Did you discuss this deposition with anyone other than Mr. Sutherland and Mr. Mitchell?
A. No.
Q. And how much time in total do you estimate that you spent preparing for today?
A. Approximately three or four hours.
Q. And besides those meetings and reviewing the three documents you listed, what else did you do during that three and four hours?
A. Listened attentively.
Q. What is your highest level of education?
A. M.D.
Q. When did you earn that degree?
A. 19- --
MR. SUTHERLAND: I'm going -- I'm going to instruct the Physician not to answer the specific year. But he can give approximately how many years ago.
THE WITNESS: Approximately 40 years ago.
BY MS. NELSON-MAJOR:
Q. And did you complete any coursework subsequent to medical school?
A. I do not understand the question.

Q. Did you have any other training beyond medical school?
A. Yes.
Q. And what was that?
MR. SUTHERLAND: You can describe it generally.
THE WITNESS: A residency training.
BY MS. NELSON-MAJOR:
Q. In what field of medicine was your residency training?
MR. SUTHERLAND: You can answer the question.
THE WITNESS: General surgery.
BY MS. NELSON-MAJOR:
Q. Do you hold any professional licenses?
A. No.
Q. Do you hold a medical license?
A. Yes.
Q. Is your medical license active?
A. In which state?
Q. I'm not going to ask you to identify a state.
MR. SUTHERLAND: The question is, you can answer if you have a valid license to practice medicine.

THE WITNESS: Yes.

BY MS. NELSON-MAJOR:

Q. Do you have a valid medical license to practice medicine in more than one state?

A. No.

Q. Do you have medical licenses in other states that are no longer active?

A. Yes.

Q. And generally, what is your medical specialty?

A. General practice.

Q. And when you say "general practice," is that family medicine?

A. Basically.

Q. And do you hold any certifications?

A. No.

Q. Are you Board certified in any particular medical field?

A. No.

Q. Do you have any military training?

A. No.

Q. Do you participate in any volunteer programs?

A. Not currently.

Q. Are you currently employed?

A. Yes.
Q. Can you generally describe to me the type of institution at which you currently practice medicine?
A. A primary care clinic.
Q. And what is your current job title?
A. Physician.
Q. And how long have you held that position?
A. Over ten years.
Q. You're not an anesthesiologist; is that correct?
A. Correct.
Q. Do you have any specialized training in anesthesiology?
A. No.
Q. What about pharmacology?
A. The general training that all physicians get.
Q. And what was your employment prior to the outpatient clinic at which you currently work?
MR. SUTHERLAND: You can just -- you can answer generally.
THE WITNESS: Self-employed.
BY MS. NELSON-MAJOR:
Q. What do you mean by "self-employed?"

A. I had my own practice.
Q. Was that also family medicine?
A. No.
Q. What type of practice was that?
MR. SUTHERLAND: You can answer generally.
THE WITNESS: Generally, surgery.
BY MS. NELSON-MAJOR:
Q. And what sorts of surgeries did you perform while in your solo practice?
A. Generalized procedures.
Q. And how long did you maintain that solo practice?
A. Four years.
Q. And what types of procedures did you perform while self-employed?
A. Those within the purveyance of a general surgeon.
Q. Can you give me some examples of the types of surgeries that you performed?
A. Herniorrhaphies, laparoscopic cholecystectomies.
MS. NELSON-MAJOR: I'm sorry, Rhonda, were you able to catch the answer?
Okay. Rhonda's indicating that she was

able to hear that.
BY MS. NELSON-MAJOR:
Q. While performing those surgeries, did you monitor the patient for anesthetic death?
A. No.
Q. Was somebody else responsible for doing that during the surgeries you performed?
A. Yes.
Q. And who -- who, without naming names, was responsible for that?
A. The anesthesia department.
Q. And why were you not also performing that function during the surgeries?
A. I was devoting my entire attention to the procedure.
Q. Over the course of your 40-year career, did you have occasion to monitor -- excuse me -- monitor anesthetic death of a patient undergoing surgery?
A. I'm sorry, ma'am, I did not understand the question.
Q. Over the course of your medical career, have you ever monitored a patient in surgery for anesthetic death?
A. Yes.

Q. And when was that?
A. During most endoscopies and minor procedures, twilight sleep is used.
Q. You said endoscopies, and what was the other procedure you mentioned?
A. Other minor procedures.
Q. So when performing an endoscopy or other minor procedures, there was not a separate anesthesiologist or similarly trained professional in the room with you?
A. No.
Q. And when was the last time that you monitored anesthetic death during one of those procedures?
A. 2006.
Q. And during the other surgeries that you performed that are not minor procedures, was there always an anesthesiologist in the room for those procedures?
A. Or a CRNA.
Q. Have you ever monitored a patient to ensure that they were under a surgical plane of anesthesia?
A. No.
Q. Are you aware that the subject of this

deposition concerns your involvement in executions carried out in Tennessee?

A. Again, could you repeat the question?

Q. Are you aware that the deposition today is related to your involvement in executions carried out in Tennessee?

A. Yes.

Q. And what is the title of the role that you play in Tennessee executions?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Physician-slash-provider.

BY MS. NELSON-MAJOR:

Q. You said "physician-slash-provider?"

A. Yes.

Q. And do you serve in this role for all executions carried out in Tennessee, regardless of the method?

A. Only the ones since February 2018, I think.

Q. I'm sorry, what year?

A. 2018.

Q. Was the first execution that you attended in 2018?

A. I'm assuming.

Q. You're assuming? Is that what you said?
A. Yes, ma'am.
Q. Prior to 2018, did you have any involvement in executions carried out in Tennessee?
A. I do not recall.
Q. How did you come to serve as the physician-slash-provider in Tennessee executions?
MR. SUTHERLAND: You can give a very general description of how you came to hold that role, without saying anything that might lead to discovery of your identity.
THE WITNESS: A conversation with I think he's the Assistant Commissioner, Lee Dotson, inquiring if I would be interested in participating.
BY MS. NELSON-MAJOR:
Q. And I was having a bit of trouble hearing. You had a conversation with an assistant commissioner; is that what you said?
A. Let me use his name in case it wasn't his title, if that's all right. Lee Dotson.
Q. Lee Dotson?
A. Yes.
Q. And when Lee Dotson approached you, what did Mr. Dotson ask you?

A. I do not remember the specifics of the conversation.
Q. Did Mr. Dotson outline what your duties would be as provider-slash-physician?
A. In a general way, yes.
Q. And what was that general description that was given to you?
MR. SUTHERLAND: Object to the form.
BY MS. NELSON-MAJOR:
Q. You can answer.
A. That I would be available to pronounce the time of death and perform any necessary procedures, if needed.
Q. And what was your understanding of what those procedures might be?
A. At that time, a venous cutdown.
Q. You said "At that time." At some point, did your understanding of what procedures you might be called on to perform change?
A. No.
Q. And did you indicate that you were willing to do that?
A. I don't recall the specifics. But again, I'm sure I did.
Q. Did you have to provide Mr. Dotson with a

resume?

A. Could you repeat your question?

Q. Did you provide Mr. Dotson with a copy of your resume?

A. I don't recall now.

Q. Do you recall whether you had to submit a copy of your medical license?

A. Again, I don't recall.

Q. Other than your conversation with Mr. Dotson, did you discuss this opportunity with anyone else affiliated with TDOC?

MR. SUTHERLAND: You can answer, without identity -- identifying anyone by name.

THE WITNESS: Yes.

BY MS. NELSON-MAJOR:

Q. And without providing their names at this point, who were those people?

A. Additional personnel associated with the Tennessee Department of Correction.

Q. Were those people that you spoke with involved in the Execution Team?

A. No.

Q. Were they part of the administration at TDOC?

A. Yes.

Q. And how many such conversations did you have?
A. I don't recall an exact number.
Q. Did those conversations occur prior to you agreeing to serve as the physician-slash-provider?
A. Yes, ma'am.
Q. And what was discussed at those meetings?
A. Again, I don't recall specifics.
Q. Were they in person?
A. No.
Q. Were they over the phone?
A. Yes.
Q. Were there email conversations?
A. That, I don't recall.
Q. And I'm going to ask a question. Who at TDOC -- without naming their names, I'm asking for those roles -- was involved in those conversations?
A. I'm sorry, could you speak a little slower and repeat the question?
MR. SUTHERLAND: I'm sorry to interrupt. So the Physician wears hearing aids, and he is not wearing those right now because we've got the earbuds in. So I just -- doctor, I didn't want to -- I didn't want to necessarily offer that, but I just want to make everybody aware of that so

when he keeps asking, it may have to do with that issue.

MS. NELSON-MAJOR: Thank you. And I'll try to speak slower and clearer.

BY MS. NELSON-MAJOR:

Q. My question is: What were the roles of the people from TDOC that you met with before deciding to serve as the Physician?

A. Administrative roles.

Q. Did you meet with the Warden of Riverside Prison?

A. Not prior to.

MR. SUTHERLAND: If you know the roles of the persons you can identify the role, the specific role, but not give a name.

THE WITNESS: All right.

MR. SUTHERLAND: Or if you know their title.

THE WITNESS: Are you waiting?

BY MS. NELSON-MAJOR:

Q. I'm sorry. Go ahead.

A. Are you waiting on me?

Q. I am.

A. I'm sorry, is there a question?

MS. NELSON-MAJOR: Yes. And

Mr. Sutherland, because these individuals are actually part of the administration and not part of the team responsible for carrying out executions, I don't believe that the names or the titles of the individuals from TDOC who met with the Physician would be subject to the confidentiality order.

Would it be okay if the Physician went ahead and named those names? I don't see how that implicates the confidentiality order.

MR. SUTHERLAND: I'm going to instruct the witness to identify the roles, if he knows, or the position of those individuals, based on the protective order.

So if you know the roles to the other people that you spoke with prior to entering into the agreement, if you can state those roles.

THE WITNESS: Tony Parker, Commissioner of TDOC.

MR. SUTHERLAND: And if there's anybody else, if you can state what their role is but not give their name.

THE WITNESS: Understood.

MR. SUTHERLAND: Is that the only person that you spoke with, other than Mr. Dotson?

THE WITNESS: Yes.

BY MS. NELSON-MAJOR:

Q. And during that conversation with Commissioner Parker, did you agree to serve as the Physician?

A. I don't recall exactly.

Q. Did you ask Mr. Parker any questions?

A. Again, I do not recall the specifics of the conversation.

Q. How many executions have you attended in Tennessee?

A. I don't know the exact number.

Q. And you stated a moment ago that you don't specifically recall what was discussed during that meeting. Do you have a general recollection of the topics that you might have discussed?

A. Only in a general sense, if I would be willing to function as the Physician.

Q. Did you discuss during that meeting the drugs that Tennessee uses in lethal injection?

A. I don't recall.

Q. And since signing on as the Physician, have you attended both lethal injection and electrocution executions?

A. Yes.

Q. Are you aware of an execution that TDOC has conducted since you came on board that you did not attend as the Physician?

A. I'm not aware of it, no.

Q. Are you aware of whether there's another individual who also serves as the Physician or provider for TDOC?

A. No.

Q. At any point in time, did you have a conversation with someone from the general counsel's office about serving as Physician or provider?

A. Not that I recall.

Q. Do you receive compensation for serving as the Physician?

A. Yes.

Q. How much do you receive?

A. $3,000.

Q. $3,000 per execution?

A. Yes.

Q. Did you negotiate that rate with TDOC?

MR. SUTHERLAND: Objection.

THE WITNESS: No.

BY MS. NELSON-MAJOR:

Q. Who did you discuss your compensation with before agreeing to be the Physician, without --

MS. NELSON-MAJOR: You can go ahead. Sorry, Mr. Sutherland.

MR. SUTHERLAND: I was saying, you can identify generally the role of the person without identifying them.

THE WITNESS: No one.

BY MS. NELSON-MAJOR:

Q. How did you learn that you would be -- you were to be compensated $3,000 per execution?

A. When I signed the contract.

Q. Has that rate changed at any point in time?

A. If you asked me has it changed at any point in time, the answer is "No."

(Exhibit No. 80 marked.)

BY MS. HAYDEN-MAJOR:

Q. Please pull up Exhibit 80 -- eight-zero.

MR. SUTHERLAND: Ms. Nelson-Major, I provided the Physician with a paper copy of that this morning. Everything else is on a thumb drive but that -- but that one, so it may not be numbered.

It's the only -- it's the only paper exhibit that was provided.

THE WITNESS: I have the paper in front

of me.

BY MS. NELSON-MAJOR:

Q. Do you recognize this document?

A. Yes.

Q. What is it?

A. An agreement between the Tennessee Department of Correction and the Physician.

Q. Is that -- are you referring to yourself when you say "Physician?"

A. Yes.

Q. Did you sign this contract?

A. Yes.

Q. And when did you sign it?

A. 2/20/2018.

Q. When you signed this agreement, did you know which methods of execution TDOC was using to carry out executions?

A. No.

Q. You didn't ask?

A. No.

Q. Has TDOC in fact paid you $3,000 for each of the executions at which you served as the Physician?

A. Yes.

Q. If you could look at Paragraph B, which states: "TDOC agrees to the following," and I'm

looking at No. 3 underneath B, which states:

"In the event the provider is called upon to perform his service and a stay of execution is granted the inmate, the provider will be compensated at the sum of $125 per hour. This will be an hourly rate to include travel time and time waiting and preparing for the execution. This same rate shall apply to any meetings to discuss procedures."

What is meant by "meetings to discuss procedures?"

MR. SUTHERLAND: Object to form. You can answer.

THE WITNESS: Some prior procedures where we went through all the protocols that were to be used were practiced.

BY MS. NELSON-MAJOR:

Q. When you said "when we went through prior protocols to be used," who is "we?"

MR. SUTHERLAND: Don't identify anyone by name, just that you can describe what you're talking about.

THE WITNESS: The team that was to be involved in the procedure would have practice

sessions.

BY MS. NELSON-MAJOR:

Q. How many such meetings did you attend?

A. Two, that I recall.

Q. And when did those meetings occur?

A. Within the past three years.

Q. Did they occur in 2018?

MR. SUTHERLAND: Objection.

THE WITNESS: The first --

MR. SUTHERLAND: You can answer.

THE WITNESS: The first one occurred prior to any execution.

BY MS. NELSON-MAJOR:

Q. And when did the second one occur?

A. Approximately six to eight months ago.

Q. The meeting that occurred prior to an execution that you mentioned, do you mean prior to any execution at which you attended as Physician?

A. Yes.

Q. What happened at that meeting?

A. Their protocol was reviewed and equipment was examined, made sure it was adequate. And suggestions were made.

Q. How many people, approximately, were at that meeting?

A. It consisted of the entire team of approximately eight to ten individuals.
Q. Did you lead that meeting?
A. No.
Q. Did someone from TDOC administration lead that meeting?
A. No.
Q. Did someone involved in carrying out the actual execution lead that meeting?
A. Yes.
Q. Without naming their name, what was their title?
A. I can't even give you the title.
Q. Were they an EMT responsible for setting an IV line?
A. No.
Q. Were they the Executioner, who prepares and administers the drugs?
A. I don't know who prepares and administers the drugs.
Q. I'm sorry, I had trouble hearing.
A. I don't know who prepares and administers the drugs.
Q. What was your understanding of the role that person who led the meeting plays in the

executions, or did you not have an understanding?

A. He just appeared to be the leader of the group.

Q. But you're unaware of the role that person serves during an execution?

A. I'm unaware of what his official title is.

Q. Are you also unaware of what he does during an execution?

A. Yes.

Q. And you said one of the things you did was to review the protocol. How did you review the protocol?

A. Went through it with them and suggested changes where appropriate.

Q. And when you say "went through it," did you go through it page by page?

A. I don't recall.

Q. Did someone describe orally the protocols that are followed during an execution?

A. No, they were reviewed on paper; but page by page, I don't recall.

Q. And you said suggestions were made. By whom, without naming names?

A. By me.

Q. And what changes did you suggest?
A. Suggested adding if a peripheral vein access couldn't be obtained to insert a central venous line.
Q. Is that the only change you suggested?
A. Yes.
Q. And why did you make that suggestion?
A. Not knowing any of the inmates' history, if they were unable to obtain IV access to a peripheral venous system maybe scarred from years of drug abuse. And a central venous line seemed like a more reasonable suggestion.
Q. More reasonable suggestion than what?
A. A cutdown.
Q. And after you made that suggestion, what was the response?
A. The equipment is there and available now.
Q. The equipment to perform a central venous line?
A. Yes.
Q. And what equipment would that be?
A. There are standardized kits from the pharmacological/surgical businesses.
Q. And again, without naming names, who informed you that there was a kit on hand to perform a

central venous line?

A. Could you repeat the question?

Q. You stated that one of the meeting participants indicated there was equipment on hand to insert a central venous line. Who informed you that that equipment was available?

MR. SUTHERLAND: Don't identify anybody by name. You can state what their role is, if you know.

THE WITNESS: After the suggestion was made, the next time I attended a procedure the equipment was shown to me so I knew it was available.

BY MS. NELSON-MAJOR:

Q. When you say "procedure," do you mean an execution?

A. Yes.

Q. Was that at the first execution you attended?

A. Can you define the question?

Q. You were shown a standardized kit, you said, at an execution. I'm asking you, was -- were you shown that kit at the first execution you attended?

A. I'm assuming it was present after the first practice session.

Q. I'm asking about when you were first shown that kit. You said you were shown the kit at an execution.

A. No, ma'am. I gave the suggestion at the practice session, and then the next time I was there I was shown the kit. So since the practice session happened before the execution, it would have been available for the first execution.

Q. I'm still talking about this first meeting in 2018. You said you reviewed equipment. What equipment did you review?

A. The medical equipment they have for the execution.

Q. And what specifically was that equipment?

A. They have a list and the protocol; and it's up to date, other than the central line set is not included.

Q. You said the central line is not included on that list?

A. No.

Q. Besides the suggestion to perform a central venous line instead of a cutdown, did you make other suggestions?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Not that I recall.
BY MS. NELSON-MAJOR:
Q. Was it decided at that meeting that a central venous line would be the first choice of procedure if peripheral IV access was not obtained?
MR. SUTHERLAND: Object to the form. You can answer, if you know.
THE WITNESS: I think it was left to the Physician's discretion.
BY MS. NELSON-MAJOR:
Q. And then you said after this meeting in 2018 you attended a practice session. How close in time was this practice session to that initial 2018 meeting?
A. I don't recall.
Q. How many practice sessions have you attended since signing on as the Physician?
A. Two.
Q. And the first practice session was before you attended an actual execution?
A. Yes.
Q. And when did the second practice session you attended occur?
A. Approximately six to eight months ago.
Q. And you initially said that you attended

two protocol review meetings; one -- the second one, which was six to eight months ago. Is that the same meeting as the practice session that you just referred to?

A. Yes.

Q. Without naming names, who was at that second practice session?

A. All members of the team, including the Warden and the Assistant Warden.

Q. Were the Warden and the Assistant Warden at that first meeting in 2018?

A. I don't recall.

Q. Who invited you to attend these two practice sessions?

MR. SUTHERLAND: Don't identify anyone by name; but you can state -- you can identify them by title, if you know.

THE WITNESS: It would be administration at TDOC would let me know by either call or text message.

BY MS. NELSON-MAJOR:

Q. Was it the Warden?

A. No.

Q. Was it the Assistant Warden?

A. No.

Q. Was it Mr. Dotson?
A. Yes.
Q. And when Mr. Dotson called or texted you, what did he say that the meetings would be about?
A. He would just let me know if there was going to be a practice session or the real thing, and when it was scheduled.
Q. Did you ever text about matters other than scheduling?
A. Could you repeat, please?
Q. Did you and Mr. Dotson ever text about anything other than scheduling?
A. No.
Q. And when you say "a practice session," do you mean a rehearsal for a lethal injection execution?
A. Yes.
Q. At the second practice session, which you said occurred six to eight months ago, did you also review the protocol?
A. I don't recall exactly, but I generally do at the practice sessions.
Q. Did you also make suggestions at this practice session?
A. No.
Q. Did you discuss your suggestion that the

first alternative choice for IV access be central venous line access?

MR. SUTHERLAND: Objection to the form. You can answer.

THE WITNESS: Again, central venous access is a possible alternative to a cutdown. It depends on the situation.

BY MS. NELSON-MAJOR:

Q. Did you discuss the possibility of performing a central venous access procedure at that second rehearsal?

A. No.

Q. Were the Warden and Assistant Warden present when the protocol was reviewed at that second session?

A. I don't recall the practice session had been limited to what the Physician would do during the real scenario, so I was only in the room for five minutes.

Q. So when you say you were only in the room for five minutes, which room are you referring to?

A. The execution chamber.

Q. Was there any meeting held prior to starting the rehearsal?

A. I don't recall specifically.

Q. Do you recall whether there was a meeting held after the rehearsal?

A. Again, I don't recall.

MS. NELSON-MAJOR: We've been going for a bit over an hour. Do you want to take a ten-minute break and we can reconvene at 20 after?

MR. SUTHERLAND: Yeah, that'll be fine.

THE VIDEOGRAPHER: We're off record. The time is 11:07 a.m.

(Recess at 11:07 a.m. to 11:19 a.m.)

THE VIDEOGRAPHER: We're back on record at 11:19 a.m.

BY MS. NELSON-MAJOR:

Q. Physician, I'm still looking at Exhibit 80, Paragraph B, and No. 4 under Paragraph B, which provides: "TDOC will process payment for services rendered upon receipt of invoice."

Have you submitted invoices to TDOC for the services you've performed as Physician?

A. No.

Q. Do you tell TDOC the number of hours you work under this contract in some other way?

A. No.

Q. How does TDOC know how much to pay you?

MR. SUTHERLAND: Object to the form. You

can answer.

THE WITNESS: That would be a question for them.

BY MS. NELSON-MAJOR:

Q. Has TDOC paid you $125 per hour for the meetings that we just discussed?

A. I've never submitted an invoice.

Q. My question was: Has TDOC paid you for participation in those meetings we just discussed?

A. Since I haven't submitted any invoices, no.

Q. So the only payment TDOC has provided to you is the $3,000 per execution?

A. Yes.

Q. Why haven't you submitted invoices for your time at the meetings?

A. Personal choice.

Q. And what are the reasons for that personal choice?

A. They're personal.

Q. Can you explain to me those personal reasons?

A. No.

Q. Why not?

A. I don't think it has anything to do with

this. I have a friend in Nashville. How about that?

Q. I posed a question to you, and you're required to answer it unless instructed to not answer by Mr. Sutherland.

A. What's the question?

Q. I'm sorry, I couldn't hear you.

A. What's the question?

Q. The question is: What are the reasons you have not billed TDOC for your time spent discussing procedures at the meetings?

A. Did not feel like it was justified.

Q. You felt like not submitting your invoices was justified?

A. Yes.

Q. Explain that to me.

A. I'd done nothing of service.

Q. You did nothing of service?

A. Correct.

Q. But you feel differently about the $3,000 per execution?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: A medical opinion is offered.

BY MS. NELSON-MAJOR:

Q. I'm sorry, state that again. I couldn't hear your answer.
A. A medical opinion is offered.
Q. And what medical opinion is offered?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: That death has occurred and the time of death.
BY MS. NELSON-MAJOR:
Q. Are you providing these services to TDOC as a favor to a personal connection of yours?
A. No.
Q. If you're not providing these services as a favor to a personal connection, why are you doing this work pro bono then?
A. Because I also work for farmers for free. I don't charge them.
Q. You provide medical care to farmers for free? Is that what you're saying?
A. No, I work on their farms for free.
Q. What sorts of work do you provide for farmers?
A. Drive semi trucks, big tractors. Plant fields.
Q. Do you provide other medical services pro

bono outside of your work for TDOC?
A. Yes.
Q. In what context?
A. Patient calls.
Q. Prior to joining as Physician, did you ever have a conversation with the prior Physician who performed this role previous to your involvement?
A. I was unaware of any other Physician.
Q. Does anyone report to you in your role as Physician?
A. Where?
Q. Does anyone report to you in your role as Physician in connection with executions in Tennessee?
A. Report to me, no.
Q. Do you report to anyone else in your capacity as Physician?
A. No.
Q. Have you ever attended an execution conducted in a state other than Tennessee?
A. No.
Q. Have you provided training to anyone in conjunction with an execution in another state?
A. No.
Q. Have you discussed proposed changes to Tennessee's lethal injection protocol with anyone

affiliated with TDOC?

A. Please repeat.

Q. Have you ever had conversations with anyone affiliated with TDOC about proposed changes to the execution protocols?

A. If you're talking about the drug protocol, no.

Q. So you've never had a discussion with anyone affiliated with TDOC about which drugs should be used?

A. No.

Q. Or how to obtain drugs to be used?

A. Or how to obtain?

Q. Yes.

A. I may have had a discussion with Commissioner Parker at one time.

Q. When was that conversation?

A. Three or four years ago.

Q. When you say "Three or four years ago," did you have conversations with people affiliated with TDOC prior to signing that contract to become the Physician?

You can answer.

A. We have -- we have a prison in our county, so I've had conversations with plenty of TDOC

personnel.

Q. My question was: Prior to becoming the Physician in executions, did you have conversations about executions with anyone affiliated with TDOC?

A. No.

Q. You said you had -- you might have had a conversation with Commissioner Parker about how to obtain drugs for use in executions.

A. Yes.

Q. What was the nature of that conversation?

MR. SUTHERLAND: Don't state any information that would lead -- could reasonably lead to the identification of any source of lethal injection chemicals. Otherwise, you can answer.

THE WITNESS: At that time, one of the three drugs was in short supply nationwide, and the conversation was had about whether I could help in obtaining any pharmaceuticals.

BY MS. NELSON-MAJOR:

Q. Which drug was in short supply at that time?

A. I don't recall.

Q. Do you recall whether it was pentobarbital?

A. I don't recall.

MR. SUTHERLAND: Object to the form, based on his prior answer.

BY MS. NELSON-MAJOR:

Q. And when Commissioner Parker asked you that question, what was your response?

A. I would have to research it.

Q. Research what?

A. Whether it could be obtained from an alternative source.

Q. And did you in fact do that research?

A. I'm sure I did. I don't recall it specifically.

Q. Did this conversation occur prior to attending an actual execution for the first time?

A. I don't recall.

Q. And did you relay your efforts to Commissioner Parker?

A. I'm sure we had further discussion, yes.

Q. And what were the results of your efforts?

A. I can't recall.

MR. SUTHERLAND: Again, you can -- you can generally respond without any -- providing any information that would -- that could reasonably lead to the identification of a source.

BY MS. NELSON-MAJOR:

Q. You don't recall whether you were searching for active pharmaceutical ingredients for TDOC?

A. No. At one point, a paper prescription was generated for TDOC; however, I don't recall for which drug and where it was to be sent.

Q. Did you generate that paper prescription?

A. Yes.

Q. Was it a sample prescription?

A. I'm sorry?

Q. Was the prescription for a particular inmate?

A. No.

Q. Was it a template for future prescriptions?

A. No.

Q. Then what was it?

A. A one-time paper prescription.

Q. Was it for one particular drug?

A. Was it for a drug?

Q. Was it for one single drug?

A. As I recall.

Q. Which drug?

A. I don't recall that.

Q. Was it an amount for use in a single execution?
A. I don't recall.
Q. How did you know which drug to write the prescription for?
A. I would have had to have been informed of that.
Q. As a doctor, can you write a prescription that's not under a particular patient's name?
A. At that time, yes.
Q. Did that change at some point?
A. Yes.
Q. How did it change?
A. Electronic health records.
Q. What about electronic health records changed the process for writing a prescription for a patient or not?
A. A prescription is generated with electronic health records. It has to have that patient's name or institution listed as a patient for the electronic health records.
Q. Did Commissioner Parker ask you to write this prescription?
A. I don't recall.
Q. Did you provide that prescription to a

pharmacy?

A. I don't recall.

Q. Did you have this conversation -- a conversation about the prescription with Mr. Dotson?

A. I don't recall.

Q. Do you keep copies of prescriptions that you write in your routine medical practice?

A. No.

Q. Returning to the conversation you had with Commissioner Parker in 2018, did you locate a source of drugs for TDOC?

A. I don't recall.

Q. Do you recall how you looked for a potential source of drugs for TDOC?

A. I'm sure, like everyone, I Googled it.

Q. You Googled it?

A. I'm sure. I don't recall exactly.

Q. Was it a one-time thing, your search for an alternative source?

A. Yes.

Q. You said you had multiple conversations with people affiliated with TDOC because there's a prison in your county. Can you explain to me how those conversations have occurred?

A. I --

MR. SUTHERLAND: I'm going to -- I'm going to -- so I'm going to object, unless they have something to do with your contract. I'm going to object to anything that's going to lead to the identification of any prison location, state or otherwise.

So don't answer the question, to the extent that it causes you to identify any specific prison or location or personnel.

THE WITNESS: Gotcha.

BY MS. NELSON-MAJOR:

Q. You can answer.

A. And the question?

Q. Okay. You said you've had conversations, multiple conversations, with people at TDOC because there's a prison in your county. Can you explain to me what those conversations are about?

A. Normal patient-physician conversations.

Q. Do you provide medical services to TDOC other than your contract as Physician?

A. No.

MR. SUTHERLAND: I'm going to -- yeah. I'm going to object and instruct the witness not to answer. He's already answered "No."

BY MS. NELSON-MAJOR:

Q. Do you provide care to inmates outside of TDOC?
A. No.
Q. What did you discuss during those conversations with TDOC?
MR. SUTHERLAND: Objection to the form, based on his prior answer, which was a general patient care question.
BY MS. NELSON-MAJOR:
Q. You can answer.
A. General patient-physician conversations.
Q. If you're not providing medical care to inmates, how do general patient-physician conversations occur?
A. With correctional officers that I've seen.
Q. Do you have any other contracts with TDOC --
A. No.
Q. -- other than the one we've reviewed?
A. No.
Q. And in this other capacity, had you ever had conversations about executions with anyone affiliated with TDOC?
A. No.

Q. The conversation you had with Commissioner Parker, was that in person or --
A. I'm sorry? The conversation with who?
Q. With Commissioner Parker about finding an alternative source for execution drugs. Was that in person?
A. No.
Q. Was it over email?
A. No.
Q. Was it on the telephone?
A. Telephone, yes.
Q. Have you ever had a conversation with anyone affiliated with TDOC about how to store the lethal injection chemicals?
A. No.
Q. What about how to prepare the lethal injection chemicals for use in execution?
A. No.
Q. What about establishing IV access?
A. Yes, I've had a discussion.
Q. Other than the discussion at that initial rehearsal in 2018, have you had other conversations about establishing IV access?
A. No.
Q. Have you had conversations with anyone

affiliated with TDOC about how to perform the consciousness check?

A. No.

Q. What about the method used to pronounce death?

A. No.

Q. Have you had conversations with anyone else affiliated with TDOC about another topic related to executions that I have not listed?

A. I'm not sure how to answer that, but no.

Q. Can you please turn to Exhibit 1. At the beginning of the deposition, you stated you reviewed a lethal injection protocol. Is Exhibit 1 the document that you reviewed?

A. It's certainly similar.

Q. When did you first see this document?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: It would be at the first practice session.

BY MS. NELSON-MAJOR:

Q. And without naming names, who provided this document to you?

A. I don't recall.

Q. Approximately how many times have you

reviewed this document?
A. Twice.
Q. You said "Twice?"
A. Yes, ma'am.
Q. So once was at the practice session in 2018. And when was the other time?
A. At the practice session six to eight months ago.
Q. Were you asked to review drafts of this document by anyone?
A. Was I asked to review what?
Q. Drafts.
A. A draft?
Q. Yes.
A. No.
Q. So you didn't write any portion of the lethal injection protocol?
A. Was I responsible for any of its generation?
Q. I asked: Did you write any portion of this protocol?
A. No.
Q. And did you make any edits to any portion of this protocol?
A. I would have to go to the page about

having access. I don't have another page here.
Q. If you'd turn to Page 42, you can tell me whether that is the section you were looking for.
A. Okay. 42?
Q. Yes.
A. Okay. Yes.
Q. You provided edits to this section?
A. No, this is the section where we had -- this was added about the possibility of a central venous insertion.
Q. I'm sorry, can you repeat your answer? There's a fair amount of static right now.
A. This would be where it was added that the Physician may choose an alternative method.
Q. Did you provide a written instruction to someone to change that language in the protocol?
A. No, it was suggested.
Q. Did someone indicate to you that the protocol would be changed to reflect that suggestion?
A. Not specifically.
Q. Generally?
A. Since it showed up later, I assume someone paid attention to it.
Q. So you assume that the protocol had been changed in some way based on the fact that you

received --

A. The necessary --

Q. -- this document?

A. Yes.

Q. When you reviewed the protocol during the second rehearsal you attended, did you review the protocol to see whether that had been added to the protocol?

A. No, I did not.

Q. But you assumed that it had been?

A. I assumed that I still had the alternative of performing that procedure.

Q. Other than the suggestion regarding the central line, did you make any other edits to a version of the protocol?

A. No.

Q. Did anyone consult with you in connection with the drafting of this protocol?

A. No.

Q. No one asked you for your input on what the Physician role should entail?

A. No one asked for my advice, no.

Q. Did anyone ask for your advice on how to prevent pain and suffering during an execution?

MR. SUTHERLAND: Object to the form. You

can answer.

THE WITNESS: No.

BY MS. NELSON-MAJOR:

Q. Can you please turn to Page 19.

A. Page 19?

Q. That's right. Have you seen this page of the protocol before?

A. Yes.

Q. And what is it?

A. Defines the Physician's primary role.

Q. And "To pronounce death" is listed as your primary role during an execution?

A. Yes.

Q. Is that consistent with your understanding of your primary role during an execution?

A. Yes.

Q. Do you have any other roles?

A. Only if no intravenous access can be obtained.

Q. So Duty No. 1 states: "To be present at the time of execution in the capital punishment garage."

On the day of execution, what time do you arrive?

A. Before 5:00.

Q. Why 5:00?
A. That's the designated time we go over to Riverbend.
Q. Did someone at TDOC convey that to you?
A. Yes.
Q. Do you bring anything with you to an execution?
A. Two stethoscopes.
Q. And why do you bring two stethoscopes?
A. One is a normal stethoscope; and the other is electronic, which magnifies heart sounds 27 times.
Q. Does TDOC provide you with any other supplies?
A. No.
Q. And once you arrive, where do you go?
A. There's an anteroom adjacent to the garage.
Q. And at some point do you leave the anteroom to go to the garage?
A. After the execution is over.
Q. So you -- where are you during the actual execution, the anteroom or the garage?
A. In the anteroom.
Q. Is there a phone in the anteroom?

A. That, I don't know.
Q. Before reporting to the capital punishment garage, do you speak with anyone else involved in carrying out the executions?
A. The team gathers over in a place in the previous penitentiary block.
Q. And when you say "team," without naming names, who is that? Their roles?
A. The IV Team, the security detail, the Assistant Commissioner. The Medical Examiner's people.
Q. Is there some sort of discussion that happens at that meeting?
A. With regard to the execution, no.
Q. Is there anyone else with you in the anteroom?
A. The Warden and Assistant Warden will usually visit.
Q. At what point in the process do they visit?
A. Prior to.
Q. And what do you discuss when they visit you in the anteroom?
A. Generalized conversation; "How are you? How are you doing?"
Q. Do you discuss the execution?

A. No.
Q. Besides the Warden and Assistant Warden, does anyone else wait in the anteroom with you?
A. Other than the members of the team I mentioned.
Q. The members of the team wait with you in the anteroom during the execution?
A. Yes.
Q. Which members, without naming names, wait with you in the anteroom?
A. The Assistant Commissioner, the Medical Examiner's team, the IV Team. The prison's team.
Q. Is this all occurring before the execution is underway?
A. Yes.
Q. And once the execution is underway, where do you go?
A. I stay in that room.
Q. Does everyone else leave?
A. No.
Q. So all those people remain with you in the anteroom for the duration of the execution?
A. Yes.
Q. Including the IV Team?
A. The IV Team goes into the execution

chamber when they're called. They perform their procedure and then exit.

Q. And when they -- do they return to the anteroom after they're done?

A. Yes.

Q. And when they return, do they -- have they ever told you how -- how obtaining IV access went?

A. No.

Q. So you never discuss their efforts to obtain IV access?

A. No. I would assume they would only discuss it with me if they had difficulties.

Q. Have you ever seen the Extraction Team transport the inmate to the execution chamber?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Can you repeat the question?

BY MS. NELSON-MAJOR:

Q. Have you ever seen the Extraction Team transport the inmate to the execution chamber?

A. No.

Q. Have you ever seen the Extraction Team secure the inmate to the gurney?

A. No.

Q. Have you ever seen the IV Team insert IV catheters?
A. No.
Q. Why aren't you inserting IV catheters in the first instance?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: They have qualified emergent personnel who are doing it every day and more often than I am.
BY MS. NELSON-MAJOR:
Q. In your general medical practice, how frequently do you attempt to achieve IV access?
A. Once every three months.
Q. And is that at a regular interval?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: I'm sorry?
BY MS. NELSON-MAJOR:
Q. You said "Once every three months." Is that an approximation of how often it occurs?
A. Absolutely.
Q. And is that peripheral IV access, for the most part?
A. Always.

Q. Always?
A. Yes.
Q. Have you ever witnessed the preparation of the syringes for use in an execution?
A. No.
Q. Have you ever seen the Warden check an inmate for consciousness during an execution?
A. No.
Q. Is there a reason that you aren't performing the consciousness check?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: I wasn't asked. It's not part of my role.
BY MS. NELSON-MAJOR:
Q. Do you think you should be the person performing the consciousness check?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: I think any medical personnel could perform it.
BY MS. NELSON-MAJOR:
Q. And when you say "any medical personnel could perform it," why is that your opinion?
A. We're using very rudimentary tests that

you can use in the field without complex machinery.

Q. And what is the minimum level of medical training that someone would need to have to perform that check?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: I don't have an opinion.

BY MS. NELSON-MAJOR:

Q. And what does a consciousness check entail?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: It's a check basically doing a corneal reflex, a trapezius squeeze, a sternal rub, and shouting in the ear.

BY MS. NELSON-MAJOR:

Q. You said -- can you say those again? I lost the second one in the static.

A. Checking the corneal reflex, the trapezius squeeze, a sternal rub, and shouting their name in the eardrum -- or ears, excuse me.

Q. Is that how medical professionals are trained to conduct the consciousness check?

A. It's one of the many ways they are, yes.

Q. Is that how you were trained to conduct

the consciousness check?

A. If the situation required.

Q. And what are the other ways to assess consciousness?

A. You can stick people with needles. Some people use towel clamps nn the earlobes. You can take a hemostat and twist it between the toes.

But those are a little bit more cruel, shall we say.

MS. NELSON-MAJOR: I just want to pause for a moment and see if Ms. Sansom was able to get that answer at all.

She's nodding, indicating that she was.

BY MS. NELSON-MAJOR:

Q. And what is a corneal reflex?

A. It's basically where you get the finger close to the eye and the patient will blink.

Q. And how is a sternal rub performed?

A. How is it performed?

Q. Yes.

A. In this protocol, they drag their finger across the eyelashes.

Q. I'm asking about you listed four ways that consciousness is checked by medical professionals, and one of them you said was a sternal rub. I was

asking about a sternal rub.

A. Oh, it's just rubbing the sternum.

Q. Then you listed three or four ways of assessing consciousness that you said might be more cruel. Can you explain to me why those are more cruel than the other ways of assessing consciousness?

A. Because they cause actual pain.

Q. So they're more painful stimuli than the other four you listed?

A. Yes.

Q. Under what circumstances would you use those more painful methods of assessing consciousness?

A. I wouldn't.

Q. You wouldn't?

A. No.

Q. Are there circumstances in your medical practice where you perform consciousness checks?

A. No.

Q. Did you receive training in medical school about how to assess consciousness?

A. Since I've had a rotation in anesthesiology, I will reply "Yes."

Q. And are the methods for assessing levels of anesthesia different than the methods for assessing consciousness that you just outlined?

A. No.
Q. So those would be the same methods you would use to assess whether a patient is under general anesthesia?
A. Yes.
Q. So a sternal rub, a corneal reflex, a trap squeeze, and shouting someone's name are sufficient ways to assess whether someone is under general anesthesia for surgery?
A. Not surgical anesthesia.
Q. What level of anesthesia are they sufficient to assess?
A. I'm not an anesthesiologist. That's outside my level of expertise.
Q. How do you assess someone for surgical anesthesia, then?
MR. SUTHERLAND: Object to the form. You can answer if you know.
THE WITNESS: If they move during the procedure, they're obviously not under surgical anesthesia.
BY MS. NELSON-MAJOR:
Q. Short of a patient moving, is there some proactive way to assess for a level of surgical anesthesia?

A. Again, outside my area of expertise.
Q. Is there any sort of video feed that captures the execution chamber that you can see in the anteroom?
A. No.
Q. So Duty No. 3, again on Page 19, states: "To examine the body for vital signs five minutes after the LIC has been injected."
Do you remain in the anteroom until it's time to check the inmate for vital signs?
A. I remain until -- in the anteroom until the Warden opens the door for me to come in.
Q. So the Warden comes and gets you when it's time?
A. Yes.
Q. So you don't keep track of the five minutes yourself?
A. I have no idea when the time is started.
Q. Do you agree that five minutes is an appropriate amount of time to wait before assessing the inmate for vital signs?
A. Yes.
MR. SUTHERLAND: Object to the form. You can answer, which you did.
BY MS. NELSON-MAJOR:

Q. And what are the bases for that opinion?
A. Four minutes without a heartbeat basically renders irreversible vital signs loss.
Q. I'm sorry, how many minutes without a heartbeat is?
A. Four minutes.
Q. Do you know if the five minutes begins to run on administration of the first drug?
A. That's what the protocol says.
Q. I'm sorry, can you repeat your answer?
A. That's what the protocol says.
Q. So it's your understanding that you're assessing vital signs after the administration of the first drug?
A. My only understanding is when they invite me in. I don't know the time limit after the drug has been injected.
Q. And what vital signs do you assess?
A. Depending on the type of execution.
Q. Let's start with lethal injection. In a lethal ejection execution, what sorts of vital signs do you assess?
A. I check corneal reflex, even though they have been given a paralytic. Check for pulse. Check for spontaneous respirations. Check for carotid

pulses, check for femoral pulses.

Q. You said you would check for corneal reflex, even though they have been given a paralytic?

A. Yes.

Q. Can you explain that answer to me?

A. Just a routine habit.

Q. Is there something about the paralytic that renders the corneal reflex check less meaningful?

A. I don't think they can respond after they've been given the paralytic.

Q. So the inmate would not be able to move their eyes after the paralytic?

A. Right.

Q. And that would be true even if they were still alive?

A. Right.

Q. Does the paralytic interfere with any of the other methods you just outlined for assessing vital signs?

A. Obviously, respirations.

Q. How do you assess the corneal reflex?

A. Run a finger over their eyelids -- eyelashes, excuse me.

Q. You said you feel for a pulse. How long do you feel for a pulse?

A. Well, the entire vascular exam is going to take somewhere between two and three minutes.
Q. I'm sorry, can you repeat that time?
A. The entire vascular exam is going to take two or three minutes.
Q. What are the steps in that vascular exam?
A. Checking for carotid pulses, checking for femoral pulses, listening for any heart sounds.
Q. And how do you listen for a carotid pulse?
A. You feel for a carotid pulse. You can auscultate for one.
Q. I'm sorry, I missed the second part of that. You can also what for one?
A. Use your stethoscope to see if there's one.
Q. And when you're assessing an inmate during an execution, how do you check for that carotid pulse? Which way do you use?
A. Both.
Q. And for how long do you check for the carotid pulse?
A. It's part of the vascular exam. All of it together takes two or three minutes.
Q. I understand, and I'm asking how much

time you devote to each one of the three steps you just outlined.

A. One-third for each of the three steps.

Q. Do you keep track of the time somehow?

A. There's a clock in the execution chamber.

Q. Does the clock have seconds on it?

A. Yes.

Q. And do you use a stethoscope to listen for the carotid pulse?

A. Yes.

Q. And which stethoscope?

A. Both.

Q. So you switch at some point?

A. Yes.

Q. And what about for the femoral pulse?

A. Femoral, all you can do is feel.

Q. You can't listen for that one?

A. No.

Q. And how long do you listen for the femoral pulse?

A. I palpate both sides approximately a minute.

Q. A minute each, or a minute total?

A. A minute total.

Q. And how do you listen for heart sounds?

A. With a stethoscope.
Q. Which stethoscope?
A. Yes.
Q. Which one, the electronic or the regular one?
A. Both.
Q. Do you switch?
A. Yes.
Q. And how long do you listen for heart sounds, total?
A. A minute.
Q. You said you also check for spontaneous respirations.
A. Yes.
Q. How do you do that?
A. See whether their chest is rising and falling rhythmically.
Q. If the chest is rising and falling, but not rhythmically, what does that indicate?
A. It could be agonal respirations.
Q. And what is that?
A. Respirations one has while they're dying.
Q. And how long do you look for spontaneous respirations?
A. The whole time I'm in the room.

Q. So while you're conducting the other checks?
A. Yes, yes, yes.
Q. Have you ever observed spontaneous respirations in an inmate during a vital signs check?
A. No.
Q. Have you ever observed anything during your vascular exam during an execution?
A. Other than negative, no.
Q. Do you check an inmate's blood pressure during the vital signs assessment?
A. No.
Q. Do you use an EKG?
A. No.
Q. Anything else that we haven't covered?
A. No.
Q. You said the process is different when you're assessing for vital signs during an electrocution execution. How is it different?
A. With an electrocution execution I don't know what the electrical discharge has done to the heart, so I pay more attention with my electronic stethoscope.
Q. You said you pay more attention to the electronic --

A. Yeah.
Q. -- stethoscope?
A. Yes.
Q. Why?
A. I think it's more accurate.
Q. Have you followed the same protocol at every lethal injection execution for assessing vital signs?
A. Yes.
Q. Is anyone else in the execution chamber with you when you're assessing vital signs?
A. Only the first time.
Q. And who was that person, without naming names?
A. Another physician.
Q. And what was your understanding of why that other physician was also present?
A. Basically, the contract, I'm supposed to have a substitute if I'm not available.
Q. Did you arrange for that substitute to be present?
A. I was checking to see if they would be interested.
Q. And as a result of that person's attendance did they also sign a contract with TDOC, if

you know?

A. I don't know the answer to that.

Q. Was that the only execution that person has attended during your tenure?

A. Yes.

Q. Do you know whether that person indicated to TDOC that they were willing to be the substitute?

A. I don't know the answer to that.

Q. Again, without naming names, this is a person that you know outside of your work with TDOC?

A. Yes.

Q. Did you detect signs of life in any of the inmates that you assessed for vital signs?

A. I'm sorry, did I detect signs of life?

Q. In any of the inmates that you assessed for vital signs following a lethal injection execution?

A. No, I have not.

Q. Duty No. 4 states: "Notify the Warden that the inmate is not legally dead." What does "legally dead" mean?

A. Does not fit the criteria for legal death.

Q. And what are the criteria for legal death?

A. Depending on which one you use, the

irreversible cessation of all vital signs.

Q. Is that the definition that TDOC supplied to you?

A. No.

Q. Where does that definition come from?

A. Google.

Q. Google?

A. Uh-huh.

Q. When did you Google the definition of "legally dead?"

A. Six months ago.

Q. And why did you Google that term?

A. I think it had something to do with a COVID patient on ECMO.

Q. I'm sorry, can you repeat that answer? I'm having trouble with the voice modulator.

A. It had something to do with a COVID patient on ECMO.

Q. And prior to six months ago, what definition of "legally dead" were you using?

A. My own.

Q. Did you say "Mine?"

A. My own.

Q. And what is your own definition?

A. Irreversible cessation of all vital signs

or vital functions.

Q. And where does that -- where did you get that definition from?

A. My years of practice.

Q. And how would you notify the Warden if the inmate was not legally dead?

A. Directly, verbally.

Q. Is the Warden in the execution chamber with you while you are pronouncing death?

A. Yes.

Q. What would you do if the inmate was not dead?

A. Notify the Warden and immediately leave --

MR. SUTHERLAND: Object to the form. I'm sorry, object to the form. You can answer.

THE WITNESS: Notify the Warden and leave the execution chamber.

BY MS. NELSON-MAJOR:

Q. Would you tell the Warden any other instructions if the inmate was not dead?

A. It depends on the situation.

Q. And what is -- what do you mean by "depends on the situation?"

A. There are several hypotheticals that

could occur that he would need to know about. If I saw one of them, I would notify him before I left the execution chamber.

Q. Have you ever discussed with the Warden those hypotheticals?

A. No.

MS. NELSON-MAJOR: I think now is a good time to take a break, if that's okay with you, Mr. Sutherland and Physician.

MR. SUTHERLAND: Just a regular break?

MS. NELSON-MAJOR: I mean, I would be fine pausing for a longer break for lunch. I don't know if that's too early on your end, but --

MR. SUTHERLAND: No, that's fine.

MS. NELSON-MAJOR: Do you want to come back at 1:00 Eastern, 12:00 Central?

MR. SUTHERLAND: Yup, that'll be fine.

MS. NELSON-MAJOR: All right. Thank you.

MR. SUTHERLAND: All right. You bet.

THE VIDEOGRAPHER: We're off record at 12:21 p.m.

(Recess at 12:21 p.m. to 12:59 p.m.)

THE VIDEOGRAPHER: We are back on record at 12:59 p.m.

BY MS. NELSON-MAJOR:

Q. Physician, when we left off you were saying that there are a number of hypothetical situations you could imagine that might occur when an inmate is not dead when you assess them. What are some of those hypothetical situations you had in mind?

A. Hypothetically, you could have a vein blow out while the injection was being given and the medication wouldn't be -- all of it given intravenously.

Q. Were there other hypothetical situations you had in mind?

A. That was the main one.

Q. And if that had occurred, what would your instructions to the Warden be?

A. I -- I would again inform him of such, leave the room, and the IV Team would come back in.

Q. And back on Page 19 of Exhibit No. 1, I'm looking at No. 5, which states: "Pronounce death if no vital signs are detected."

Do you notify the Warden that the inmate is legally dead?

A. Yes.

Q. And then after you pronounce death, what do you do?

A. Leave the execution chamber.

Q. So you're not present when personnel from the Medical Examiner's Office examines the body?
A. No, I come back in later.
Q. So after you pronounce death, you leave. And then are you summoned back into the execution chamber at some point?
A. No. When the Extraction Team is called, I go back into the execution chamber and stand in a corner until -- while the body is examined and when it is put on a gurney and taken out.
Q. And do you do anything while that examination is occurring?
A. No.
Q. What's the purpose of you being in the room during that examination?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: Make sure there's been error in -- no error in the diagnosis of death.
BY MS. NELSON-MAJOR:
Q. And how do you do that?
A. Notify that the body is not moving or having any spontaneous respirations.
Q. So you continue to monitor the body for vital signs while the Medical Examiner's personnel is

doing their examination?
A. Only a cursory visual exam.
Q. Do you sign the death certificate?
A. I don't recall that I ever have.
Q. Are you present when the body is removed from the execution chamber?
A. Yes.
Q. If you've already pronounced the inmate legally dead, why are you continuing to monitor the inmate for vital signs on an observational basis?
A. To make sure there was no errors.
Q. And have you ever visually observed vital signs in an inmate during that time?
A. I have never visually observed any movement or spontaneous respirations.
Q. And if you're aware, has the Medical Examiner's Office personnel ever observed that?
A. I can't speak --
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: I can't speak for them.
BY MS. NELSON-MAJOR:
Q. Have you ever had a discussion with anyone at TDOC about how a particular execution went after the fact?

A. None that I recall.
Q. And in the days leading up to an execution, do you have any involvement?
A. No.
Q. So you don't examine the inmate prior to an execution?
A. No.
Q. Or review medical records?
A. No.
Q. Or assemble supplies?
A. Or what?
Q. Do you assemble any supplies in the days leading up to the execution?
A. No.
Q. If it was reported to you that the IV Team was unable to establish IV access, what would you do?
A. Go in and assess the inmate.
MR. SUTHERLAND: Object. Excuse me. Excuse me. Object to the form, but you can answer.
THE WITNESS: Go in an assess the inmate and decide whether a cutdown or central venous line was needed.
BY MS. NELSON-MAJOR:

Q. And what would you be looking for during that exam?
A. Track marks, sclerosed veins. No evidence of peripheral venous veins.
Q. Would you attempt to achieve -- achieve peripheral access yourself?
A. Only by means --
MR. SUTHERLAND: Object to the -- object to the form. You can answer.
THE WITNESS: Only by means of a cutdown.
BY MS. NELSON-MAJOR:
Q. Is there an ultrasound available for you to use when attempting to locate a vein during an execution?
A. No.
Q. Have you ever used an ultrasound to locate a vein to establish IV access in your practice outside of your work with TDOC?
A. No.
Q. If peripheral access was not possible, what other methods would you contemplate using during an execution?
A. Central venous access through the femoral vein.
Q. Is that the only alternative procedure

for obtaining venous access that you would consider using?

A. I'd consider that to be the safest.

Q. And why do you consider that to be the safest?

A. Anyone can do it, and you don't run the risk of a pneumo- or a hemothorax.

Q. And can you explain those medical terms you just used. What is a pneumothorax?

A. Collapsing a lung or having bleeding into the chest cavity.

Q. And those are risks associated with what type of procedure?

A. Subclavian vein central cannulization.

Q. Are those also types of central venous catheters?

A. Yes.

Q. So the only type of central venous catheter you would attempt is in the femoral artery?

A. Vein.

Q. Excuse me. Is that the -- is the femoral vein the only type of central venous catheter you would attempt?

A. Yes.

Q. Besides the femoral vein central venous

catheter, are there other alternative methods for achieving IV access that you might use on an inmate?

A. No.

Q. So you wouldn't try a cutdown procedure?

A. I misunderstood the question. I thought you were addressing central venous access.

Q. Oh, excuse me. Besides central venous access through the femoral vein, what other alternatives to peripheral access would you attempt during an execution?

A. If the situation warranted, a cutdown.

Q. And in what veins would you attempt the cutdown procedure?

A. Whichever vein was available.

Q. And when you say if the situation warranted you would consider a cutdown, what situations would warrant a cutdown?

A. The patient -- excuse me. The inmate might be so morbidly obese that they couldn't achieve peripheral access and might need a cutdown to expose the vein.

Q. Is central venous catheters in the femoral vein not possible if someone is morbidly obese?

A. Yes.

Q. You stated that you would also examine

the inmates for track marks and sclerosed veins. How would those factor into your decision about which alternative for peripheral access you would choose?

A. If the patient has totally sclerosed veins from the antecubital cuff, a cut- -- peripheral cutdown at the wrist is not going to get the medications delivered.

Q. Would you try intraosseous access during an execution?

A. No.

Q. Why not?

A. Unwarranted.

Q. What do you mean by "unwarranted?"

A. I have alternate means of access before intraosseous would ever be considered.

Q. If possible, would cental venous catheters in the femoral vein be your first choice when peripheral access is not possible?

A. Yes.

Q. And you stated that anyone can do a central venous catheter, I believe I heard. What did you mean by that statement?

A. It's a minor procedure. Surely, everybody's been exposed to it.

Q. What do you mean by "everyone's been

exposed to it?"

A. I would think that all physicians have been exposed to it during their medical training.

Q. Is a cutdown also a minor procedure?

A. To most people.

Q. "To most people?" Do you mean people in general, or doctors?

A. To most physicians.

Q. Why would you choose the femoral vein central line over a cutdown, if both are minor procedures?

A. I already answered the question.

Q. Can you repeat? I'm sorry, I'm having a hard time with the static.

A. If the evidence of all proximal veins were of sclerosis, it would not do any good to perform a distal venous cutdown because the medication couldn't get central.

Q. When you say "the medication couldn't get central," does the central venous line deliver medication more quickly throughout the body?

A. The larger veins are hardly ever involved in sclerosis from drug use.

Q. Are there safety risks associated with a cutdown that are not associated with a central venous

catheter?

A. Not that I'm aware of.

Q. Have you ever performed a cutdown during a lethal injection procedure in Tennessee?

A. No.

Q. If you could again turn to Page 19 of Exhibit 1.

A. Somehow I've lost my exhibits, so if you could get them up for me?

MS. NELSON-MAJOR: Mr. Sutherland, I don't know if you have someone available to locate the files for the Physician.

You're muted, Mr. Sutherland.

MR. SUTHERLAND: Dean, could you go in and pull the thumb drive up?

MS. NELSON-MAJOR: Thank you.

David, can we go off the record? I'm not sure this will take very long, but just in an abundance of caution. Thank you.

THE VIDEOGRAPHER: We're off record at 1:14 p.m.

(Technical pause.)

THE VIDEOGRAPHER: We are back on record at 1:16 p.m.

BY MS. NELSON-MAJOR:

Q. If you could turn to Page 19 of Exhibit 1. Do you have that up, Physician?

A. Yes.

Q. Okay. No. 2, the second duty listed is: "As an alternate or last option, the Physician may perform a venous cutdown procedure should the IV Team be unable to find a vein adequate to insert the catheter."

Who determines if the IV Team is unable to find a vein?

A. I'm sorry?

Q. If you know, who determines if the IV Team is unable to find a vein, without naming names?

A. The IV Team.

Q. Is there a time limit on how long the IV Team can attempt to achieve IV access?

A. I don't know the answer to that.

Q. What about a limit on the number of attempts that the IV Team may perform?

A. Again, I don't know their -- their criteria. I don't know the answer.

Q. Has anyone ever discussed with you how that determination is made?

A. No.

Q. Do you think you should be the person to determine whether a cutdown or alternative IV access is necessary?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: I think it should be a joint decision between myself and the IV Team.

BY MS. NELSON-MAJOR:

Q. Does the facility at which you work have any limit on the IV attempts that can be made on a patient before moving to a different procedure?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Where I work, there's no limits.

BY MS. NELSON-MAJOR:

Q. During an execution in which you have served as Physician, was there ever a time that you were told that the IV Team was having trouble establishing IV access?

A. No.

Q. Where on the body is a cutdown procedure performed?

A. Wherever a vein is.

Q. Would you perform a cutdown on an

inmate's great -- I might mispronounce this word, excuse me in advance -- saphenous vein?

A. I have done that, yes.

Q. On an inmate?

A. No.

Q. On a patient in your general medical practice?

A. Yes.

Q. Under what circumstances have you done that on a patient?

A. It was a proceeding up in the chest, they needed IV access. It was the only access I had available to me.

Q. At what location on the leg would you attempt to access the great saphenous vein at an execution?

A. At the ankle.

Q. Would you perform a cutdown on an inmate's basilic vein?

A. Basilic vein? Yes.

Q. Yes? I'm sorry. Was your answer "Yes?"

A. Yes.

Q. What about the brachial vein?

A. Brachial?

Q. Yes.

A. Yes.
Q. And of those veins, what would your order of preference be?
A. Again, depending on the situation, wherever a peripheral vein was present and there appeared to be no proximal venous obstruction.
Q. Would you examine each one of those veins as a potential site before making that decision?
A. I would examine all four extremities.
Q. How is a cutdown performed?
A. A transverse incision is made over the vein. It's isolated. Two silk sutures are placed proximally distal. A small nick is made in the vein, and a catheter is inserted and tied off with silk sutures.
Q. Would you administer an anesthetic before performing a cutdown on an inmate during an execution?
A. Absolutely.
Q. And what kind of anesthetic would you administer?
A. 1-percent lidocaine.
Q. Is that a topical anesthesia?
A. It's given subcutaneously.
Q. And what dosage of lidocaine would you administer?

A. 1 to 2 ml's would be sufficient.
Q. Do you apply a tourniquet?
A. No.
Q. And how deep is that initial external incision that you make?
A. Skin deep, 2 millimeters.
Q. And how do you isolate the vein?
A. With a hemostat.
Q. And what sort of sutures do you use when making those two tie-offs that you mentioned?
A. They're not tie-offs, they're traction devices. Any suture would work, but they have silk available.
Q. Do you secure the catheter in some fashion?
A. I'm sorry?
Q. Do you secure the catheter somehow --
A. Yes.
Q. -- after it's inserted?
A. Yes, a proximal suture --
Q. How do --
A. A proximal suture will be tied over the vein and the catheter.
Q. And what gauge catheter would you use?
A. At least an 18 gauge.

Q. Do you suture the -- would you suture the external incision?
A. In a normal situation, I would. I'm not sure I would in this one.
Q. Why not in this -- "this one," as you put it?
A. It's an execution.
Q. And why would you suture it in a normal medical setting?
A. Because it might be needed for several days.
Q. And during an execution, would you cover the site with anything?
A. Yes.
Q. With what?
A. They have sterile clear dressings that could go over the entire site.
Q. What would you do if you were unsuccessful in obtaining IV access on your first attempt to perform a cutdown procedure?
A. Go elsewhere.
MR. SUTHERLAND: Object to the form. You can answer.
BY MS. NELSON-MAJOR:
Q. What do you mean by "Go elsewhere?"

A. Obviously pick a different site.
Q. Has it ever happened to you in your general medical practice?
A. I don't recall any time.
Q. In your medical practice, has a vein ever ruptured when you were attempting to achieve access via a cutdown procedure?
A. No.
Q. What size scalpel would you use during a cutdown?
A. I would use any they have available, including a 10, 11, and a 15.
Q. Are there different situations in which you would use a different-sized scalpel?
A. No.
Q. So it doesn't matter?
A. No.
Q. Could you please turn to Page 82 of Exhibit 1.
A. 82.
Q. Have you seen this page before?
A. I'm sorry, you said 82?
Q. That's correct.
A. Mine stops at Exhibit 79.
Q. Oh. If you look at the bottom right-hand

corner there's page numbers printed at the bottom that don't correspond to the number of pages in the PDF. So look at the bottom right-hand corner for Page 82.

A. Okay. Can you give me a minute to open the file?

Q. If you turn to the --

MR. SUTHERLAND: It's Exhibit 1, Page 82. Same exhibit we were just --

THE WITNESS: Okay. Yes, sir.

BY MS. NELSON-MAJOR:

Q. Have you seen Page 82 of Exhibit 1 before?

A. I'm headed that way.

Q. Can you say that again?

A. I'm headed that way.

Q. Okay. Let me know when you have it up.

A. Okay.

Q. Have you seen Page 82 of Exhibit 1 before?

A. Yes.

Q. What is it?

A. "Lethal Injection Execution Recorder Checklist."

Q. I think we're on different pages. If you look at the bottom right-hand corner of the page.

A. Okay. I'm on 86. Okay. Yes.
Q. Have you seen this page before?
A. Yes.
Q. What is it?
A. The "Physician's Inventory Checklist."
Q. Did you come up with the list of items on this sheet?
A. No.
Q. Do you know who did?
A. No.
Q. Have you filled out this checklist before?
A. I'm sorry?
Q. Have you ever filled out this checklist before?
A. Have I filled the template out? No.
Q. Before an execution starts, do you personally collect the supplies on this list?
A. No.
Q. Does someone else gather the supplies for you?
A. Yes.
Q. And when are you given those supplies?
A. Only if needed.
Q. Who would you ask if you needed these

supplies?

MR. SUTHERLAND: Don't identify anybody by name, just position, if you know.

THE WITNESS: I can't. I don't know his name. And it's basically the team leader of the unit.

BY MS. NELSON-MAJOR:

Q. What supplies do you bring with you when you enter the chamber to assess vital signs?

A. I know you'll be glad when I put my hearing aids back in. Now, could you repeat your question?

Q. I'm sorry about that. I said: Do you bring any supplies with you when you enter the chamber to assess vital signs?

A. Two stethoscopes.

Q. And that's it?

A. Yes.

Q. Do you see listed on this page "Prep kits?"

A. Yes.

Q. What is a prep kit?

A. Basically, it's a Betadine solution to create a sterile field.

Q. And that's it?

A. Yes.
Q. And what is a "BP cuff?"
A. Blood pressure cuff.
Q. Have you ever used a blood pressure cuff on an inmate on the day of an execution?
A. No.
Q. How might you use a BP cuff during an execution?
A. If I thought the inmate was still alive.
Q. When you went to visit -- assess the inmate for vital signs?
A. Yes.
Q. If they appeared to still be alive, you might look at their blood pressure?
A. Yes.
Q. What are Chux?
A. They're basically absorbent pads for any bodily fluids that might be spilled.
Q. Why are Chux on the list?
A. I'm sorry, I thought you were asking about the Chux.
Q. I did. The question was: Why are Chux on the list?
MR. SUTHERLAND: Objection. Object to the form. You can answer.

BY MS. NELSON-MAJOR:

Q. I can restate. How might you use Chux during an execution?

A. I'm trying to find out where the Chux is.

Q. It's about halfway down the list.

A. Again, I see "Chux" but not "Tucks."

Q. I think it's just something getting lost in Zoom. I'm saying it's C-H-U-X.

A. Okay. Those -- those are Chux. Those are absorbent pads that are used to absorb bodily fluids.

Q. And how might you use them during an execution?

A. If one had to do a cutdown, you would spread one under the procedure site to catch any spilled blood.

Q. And why is lidocaine 2 percent on this list?

A. That may be what they had. It's either lidocaine 1 or 2 percent.

Q. And underneath "Lidocaine 2 percent" is "Lidocaine 2 percent with epinephrine?"

A. Yes.

Q. Are they used for different purposes?

A. No, they're both used for skin

anesthesia.

Q. And what are 4-0 VICRYL?

A. Those are just the different sutures they have. Some are absorbable, some aren't.

Q. Are VICRYL suture absorbable?

A. Yes.

Q. Are ETHILON sutures absorbable?

A. No.

Q. What kind of sutures would you use during a cutdown procedure?

A. Makes no difference.

Q. And what is a cutdown tray?

A. It will have several small hemostats and some sterile towels present.

Q. You said that there is a commercially available kit for central lines.

A. Yes.

Q. Is that right?

A. Yes.

Q. Is that on this list somewhere?

(Witness reviews document.)

MR. SUTHERLAND: You might want to reask your question, please.

MS. NELSON-MAJOR: I was giving him time, because I thought he was looking at the list.

BY MS. NELSON-MAJOR:

Q. Physician, are you looking at the list?

A. I'm trying to get back. It's 82, right?

Q. Did you lose the exhibit on the computer?

A. I'm getting there, slowly but surely.

Okay. I do not see it.

Q. But it's your understanding that one would be made available to you if necessary?

A. One is available.

Q. And you've seen it --

A. Yes.

Q. -- at the prison?

A. Yes.

Q. Does the kit contain catheters?

A. Yes.

Q. How often do you perform cutdown procedures during your normal medical practice?

A. Once in 20 years.

Q. So you've performed one total in your medical career?

A. No, ma'am.

Q. How many total would you say you've performed over the course of your medical career?

A. A hundred.

Q. When was the last time you performed a

cutdown procedure?

A. Probably 20 years ago.

Q. And how often do you achieve IV access through a central line?

A. I'm sorry?

Q. How often do you perform the central line procedure that we discussed earlier?

A. I haven't performed it since 2006.

Q. And how many times in your medical career do you think you've achieved IV access through a central line?

A. Thousands.

Q. Did you change jobs in 2006?

A. Would you repeat?

Q. Did you change jobs in 2006?

A. Yes.

Q. Was performing central lines something you routinely did at that previous job?

A. Yes.

Q. And what sort of medicine did you practice at that point in time?

A. Procedural medicine.

Q. What is procedural medicine?

A. Where procedures are performed.

Q. Are you talking about surgeries?

A. Yes.
Q. So you would establish a central venous line in a patient in conjunction -- conjunction with a surgery you were performing?
A. Or if other patients needed venous access for other physicians.
Q. Were these major surgeries?
A. Yes.
Q. I'm just finding my correct page in the protocol.
Do you have a subspecialty as a surgeon?
A. No.
Q. Could you please turn to Page 34 of Exhibit 1.
A. Okay. Are we still staying on Exhibit 1?
Q. Yes; Exhibit 1, Page 34.
A. All right.
Q. Before we get to Page 34, I want to ask you one more question about that. When you say you've performed the central lines in conjunction with surgeries, were those actual surgeries where you were the surgeon?
A. Or putting in central lines for other physicians' patients.
Q. But for some of those patients you were

actually performing the surgery?

A. Yes.

Q. What drugs does the current protocol contemplate using?

MS. HAYDEN-MAJORS: I understand you're having a hard time hearing me with the static in your hearing aids. I wonder if we should go off the record.

THE VIDEOGRAPHER: We're off the record at 1:43 p.m.

(Recess at 1:43 p.m. to 1:57 p.m.)

THE VIDEOGRAPHER: We are on record at 1:57 p.m.

BY MS. NELSON-MAJOR:

Q. Physician, we're looking at Exhibit 1, Page 34. Do you have that up still?

A. Bear with me.

Q. Physician, we're looking at Exhibit 1, Page 34.

A. Okay. Page 34?

Q. Page 34 of Exhibit 1. Do you have that up?

A. Yes.

MS. NELSON-MAJOR: I'm getting a significant amount of feedback. I can somewhat

hear the Physician; but Ms. Sansom, can you hear okay?

Yeah, I don't think that this is going to work.

(Recess from 1:58 p.m. to 2:13 p.m.)

THE VIDEOGRAPHER: We're back on record at 2:13 p.m.

BY MS. NELSON-MAJOR:

Q. Physician, what drugs does the current protocol contemplate TDOC using during an execution?

A. I can offer you the answer off the cuff.

Q. I'm sorry, I didn't catch your answer.

A. I can offer you the answer off the cuff, but I haven't gotten to Page 34.

Q. I'm asking you, to your recollection, what drugs does TDOC is?

A. Midazolam, vecuronium, and potassium chloride.

Q. And looking at Page 34 of Exhibit 1, titled "Chemicals Used in Lethal Injection," have you seen this page before?

A. Yes.

Q. What total dosage of midazolam does the protocol call for?

A. A total of 500 milligrams.

Q. And what total dose of vecuronium bromide does the protocol call for?
A. A total of 100 milligrams.
Q. And what about total dose of potassium chloride?
A. Total of 240 milligrams -- milliequivalents, excuse me.
Q. And what is your understanding of the purpose of including midazolam in the lethal injection protocol?
A. It's a benzodiazepine; an antianxiety, amnestic drug.
Q. And what are the typical uses for midazolam?
A. It's an antianxiety drug. It's used as part of an anesthetic regimen. It's also used for procedures that call for twilight sleep.
Q. And what do you mean by "twilight sleep?"
A. Where you don't really need or require an anesthesiologist, and the patient is in a restful state but they don't remember the procedure.
Q. And is that a lighter level of sedation than would be required for a surgical procedure?
A. Americans use it for endoscopies.
Q. I'm sorry, you said who uses it for

endoscopies?

A. Americans.

Q. Americans?

A. Yes.

Q. In what part of the body does midazolam work?

MR. SUTHERLAND: Can you hit the mute button when you finish your answer, doctor?

THE WITNESS: Yes. That, I don't know. I'm not a pharmacist --

BY MS. NELSON-MAJOR:

Q. Do you know --

A. -- or an anesthesiologist.

Q. -- midazolam's mechanism of action?

A. No, I don't know.

Q. How are benzodiazepines and barbiturates different?

A. I can't give you a good answer.

Q. Is midazolam typically used as an anesthetic?

A. It's used as part of an anesthetic regimen.

Q. And what regimen is it part of?

MR. SUTHERLAND: Object to the form.

BY MS. NELSON-MAJOR:

Q. You can answer.

MR. SUTHERLAND: Okay, you can answer. But when you finish your answers, can you make sure to mute yourself?

THE WITNESS: No, I can't, because I have to get off the exhibit.

BY MS. NELSON-MAJOR:

Q. You can close out of the exhibit for now. We won't be looking at it.

A. All right.

Q. So my question was: You said that midazolam is used as part of a regimen when used as an anesthetic, and I asked: What other drugs are part of that regimen?

A. I'm not an anesthesiologist. I don't know. They have multiple drugs at their disposal.

Q. Is midazolam ever used by itself to maintain anesthesia during a surgical procedure?

A. Again, I'm not an anesthesiologist. I don't know.

Q. Is there a difference between induction and maintenance of anesthesia?

MR. SUTHERLAND: Object to the form. You can answer, if you know.

THE WITNESS: I'm not an

anesthesiologist. I don't know.
BY MS. NELSON-MAJOR:
Q. Have you ever used midazolam by itself to maintain a plane of general anesthesia?
MR. SUTHERLAND: Object to the form.
THE WITNESS: No.
BY MS. NELSON-MAJOR:
Q. Was your answer "No?" I'm sorry, I lost your answer in the objection.
A. No.
Q. And you've performed surgeries where you're not monitoring or performing the anesthesia; is that right?
A. Yes.
Q. Are you aware of whether the anesthesiologist performing the anesthesia on those surgeries ever used midazolam by itself to maintain general anesthesia?
A. I'm not aware.
Q. Does midazolam have an analgesic effect?
MR. SUTHERLAND: Object to the form. You can answer.
THE WITNESS: I'm not a pharmacologist. I don't know the answer.
BY MS. NELSON-MAJOR:

Q. Have you ever prescribed or used midazolam by itself as an analgesic?
A. No.
Q. Have you used midazolam in your medical career before?
A. Personally, no.
Q. You've never given a patient midazolam?
A. No. A patient has received midazolam at an endoscopy center, but I wasn't giving it.
Q. In the course of your medical practice, are endoscopies the only procedure in which you've been involved that a patient has received midazolam by itself?
A. I don't know the answer to that.
Q. And are endoscopies performed in surgery centers or hospitals?
We missed your answer.
A. I'm sorry, could you repeat your question?
Q. Do endoscopies have to be performed in hospitals?
I didn't catch your answer.
Can you restate your answer? You were muted when you were answering.
A. An endoscopy can be performed in a

hospital or as an outpatient procedure.

Q. Are you aware that midazolam has a ceiling effect?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: No.

BY MS. NELSON-MAJOR:

Q. You're not aware, or midazolam does not have a ceiling effect?

A. No, I'm not aware of a ceiling effect.

Q. And you, to be clear, have never used midazolam by itself to maintain general anesthesia?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: No.

BY MS. NELSON-MAJOR:

Q. Are you aware that midazolam can result in a paradoxical reaction?

A. No.

Q. You're not aware that midazolam can result in a paradoxical reaction?

A. No, I'm not aware.

Q. Is midazolam acidic or alkaline?

A. Don't know the answer.

Q. What kind of drug is vecuronium bromide?

A. A paralytic agent.
Q. And what is your understanding of the purpose of including the vecuronium bromide in the lethal injection protocol?
A. To stop involuntary muscle movement, which will also stop respiration.
Q. Have you used vecuronium bromide in your medical practice?
A. Yes.
Q. And for what purposes have you used it?
A. For paralyzing patients.
Q. And under what circumstances do you use it to paralyze a patient?
A. If there's a suspected closed-head injury in the emergency department and you have to intubate the patient. If you have a sick patient on the ventilator and he's fighting it and you can't keep his oxygenation up, you can possibly paralyze them in recovery -- to recover oxygenation.
Q. And what are the therapeutic doses of vecuronium bromide?
A. I haven't used it lately enough to come up with a good answer.
Q. And when a patient is --
(Interruption.)

MS. NELSON-MAJOR: I'm just muting myself so you don't hear my office intercom. Let me turn my do not disturb on.

BY MS. NELSON-MAJOR:

Q. When vecuronium bromide is administered in a medical setting, is a patient first given some form of anesthesia?

And Physician, you're muted if you're speaking.

A. It would depend on the situation.

Q. And how would it depend?

A. If the patient were awake and alert and still required to be given a paralytic, you would obviously be giving something prior to.

If a patient is critically ill and totally unconscious, they would probably not require any other agent.

Q. And if the patient was awake and conscious when receiving the vecuronium bromide, why would you give them an anesthesia first?

A. I'm not a pharmacist or anesthesiologist.

Q. You said obviously, if a patient was conscious before giving the vecuronium bromide, they would be given anesthesia. I'm asking, what are those obvious reasons?

A. I wouldn't want to paralyze a patient who was totally awake and alert and oriented times three.
Q. Why not?
A. I suspect, if nothing else, the psychic trauma would be a problem.
Q. And the injection of the medication itself, does that cause a sensation in a patient who is conscious?
A. I don't know the answer to that.
Q. You don't know whether vecuronium bromide causes a burning sensation upon injection if administered without anesthesia?
MR. SUTHERLAND: Objection to form.
THE WITNESS: I don't know.
BY MS. NELSON-MAJOR:
Q. Is vecuronium bromide acidic or alkaline?
A. I don't know.
Q. Was the administration of vecuronium bromide -- Physician, if you can mute yourself. I'm afraid you're not going to be able to hear the question.
A. Now I'm on mute. Go ahead.
Q. Okay. Will administration of vecuronium bromide impact the ability of an observer to assess someone for consciousness?

A. I don't know the answer to that.
Q. If someone's been administered a paralytic, is it harder to assess whether that person is experiencing a reaction to a procedure or a medication?
MR. SUTHERLAND: Objection to the form. You can answer.
THE WITNESS: I would think, yes.
BY MS. NELSON-MAJOR:
Q. And why would you think yes?
A. If they were paralyzed, they couldn't spontaneously --
Q. You muted yourself in the middle of that sentence.
A. If they were paralyzed, they couldn't move and demonstrate any reaction.
Q. And what kind drug is potassium chloride?
A. It's a normal electrolyte.
Q. I'm not sure if we caught your full answer. Can you repeat that?
A. It's a normal electrolyte.
Q. And what is your understanding of the purpose of including the potassium chloride in the lethal injection protocol?
A. At the dose it's given, it causes

irregular heartbeats and cardiac asystole.

Q. Is the potassium chloride at the dose it's given, in and of itself, fatal?

A. Yes.

Q. So if an inmate was not administered the vecuronium bromide but instead just midazolam and the potassium chloride, would that be sufficient to kill the inmate?

MR. SUTHERLAND: Object to the form. You can answer.

BY MS. NELSON-MAJOR:

Q. If you're answering, you're muted.

A. I don't know the answer to that.

Q. You stated that the 240 milliequivalents of potassium chloride on its own would be fatal. Do you have a sense of how quickly it would cause death?

A. Within minutes.

Q. Would it be less than five minutes, in your opinion?

If you're answering, you're muted.

A. Yes.

Q. What would a person feel if they were administered potassium chloride without anesthesia?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Most patients report occasionally burning in their veins when you have a normal dosage.

BY MS. NELSON-MAJOR:

Q. Have you ever administered potassium chloride to a patient who has reported feeling burning in their veins?

A. No.

Q. Would you characterize the sensation caused by potassium chloride without anesthesia as a noxious stimulus?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: It's apparently unpleasant.

BY MS. NELSON-MAJOR:

Q. If an individual was administered potassium chloride without anesthesia, would they exhibit a reaction?

MR. SUTHERLAND: Object to form. You can answer.

THE WITNESS: I don't know the answer to that.

BY MS. NELSON-MAJOR:

Q. Would a physical reaction to potassium chloride, the burning sensation, signal that they're

conscious?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Given a normal therapeutic dose, yes. I don't have any information about getting massive doses.

BY MS. NELSON-MAJOR:

Q. What would the reaction look like from a person who was administered a therapy dose to the potassium chloride without an anesthetic?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: The patient apparently reports a burning sensation in the vein in which the therapeutic drug is being given.

BY MS. NELSON-MAJOR:

Q. If a person, that patient, had first received a paralytic, would they be able to exhibit that same reaction to the potassium chloride?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: I don't know the answer to that.

BY MS. NELSON-MAJOR:

Q. If a person is paralyzed but experiencing

pain, are they able to physically react?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: Yes.

BY MS. NELSON-MAJOR:

Q. They are?

A. Yes.

Q. Can you explain that to me?

A. Tachycardia and elevated blood pressure.

Q. What about to a visual inspection?

A. You wouldn't be able to see those visually.

MR. SUTHERLAND: I didn't hear the answer.

BY MS. NELSON-MAJOR:

Q. Can you repeat that, Physician? I didn't catch it.

A. You wouldn't be able to see those.

Q. All right. I'm going to ask you to pull up Exhibit 70. And I apologize for the interference that's going to cause with the muting and unmuting, but it'll be quick.

And let me know when you have it up.

A. This is a pain. This is what page?

Q. I'm sorry. Exhibit 70, the first page.

A. Okay, Page 70, Exhibit No. 1.
Q. No. Excuse me, Exhibit 70.
A. Exhibit 70?
Q. Yes, the first page.
A. I'm there.
Q. Do you recognize these documents?
A. No.
Q. You did not sign these prescriptions?
A. No.
Q. Was that "No?"
A. No. They're redacted on that copy, so I have no idea who signed them.
Q. Do you recall signing prescriptions for the ordering of lethal injection chemicals for particular executions?
A. Do I recall it? No.
Q. You recall signing the one order we talked about earlier; is that right?
MS. NELSON-MAJOR: Physician, did we lose you? Physician, are you there? It seems like something cut off sort of abruptly. I wonder if he lost audio.
MR. SUTHERLAND: Dean, can you check on that, please?
MS. NELSON MAJORS: Can we go off the

record?

THE VIDEOGRAPHER: We're off record at 12:37 p.m.

(Recess at 2:37 p.m. to 2:39 p.m.)

THE VIDEOGRAPHER: We're on record at 2:39 p.m.

BY MS. NELSON-MAJOR:

Q. Physician, the last question I asked was: Do you recall writing just the single prescription for drugs for TDOC to use during the lethal injection procedure?

A. Yes.

Q. Have you ever seen the drugs in TDOC's possession for use in lethal injection executions?

If you're answering, you're muted.

A. I don't recall.

Q. Have you ever been involved in inventorying the drugs in TDOC's possession for use in lethal injection executions?

A. Repeat, please?

Q. Have you ever inventoried the drugs in TDOC's possession for use in lethal injection executions?

A. Not that I recall.

Q. Have you ever discussed how to perform

the consciousness check with Warden Tony Mays?

A. No.

Q. Or anyone else involved in carrying out the executions?

A. No.

Q. Have you ever had a conversation with anyone on the Execution Team about contingencies for problems that might arise during an execution?

A. No.

Q. When you initially discussed performing the Physician role with TDOC, did they ask you how long ago you last performed a cutdown procedure?

A. No.

Q. Outside of your role in executions, do you supply medical care to TDOC staff?

MR. SUTHERLAND: I'm going to object and instruct the witness not to answer, based on the Court's protective order.

BY MS. NELSON-MAJOR:

Q. Have you ever been dis- -- disciplined by a medical board?

A. Yes.

Q. How many times have you been disciplined by a medical board?

A. Once.

Q. And when was that?
A. 2009.
Q. And what was the discipline that was imposed?
A. Loss of general surgical accreditation.
Q. You said loss of surgical accreditation?
A. Yes.
Q. And what were the circumstances of the events that led to the loss of your surgical accreditation?
A. Too many malpractice suits.
Q. Did that proceeding impact your medical license?
A. No.
Q. Was there a hearing in that matter?
A. No.
Q. Did you contest this allegation?
A. No.
Q. Have you ever been referred to the Tennessee Medical Foundation?
MR. SUTHERLAND: I'm going to object and instruct the witness not to answer, based on the protective order.
BY MS. NELSON-MAJOR:
Q. Why didn't you contest the allegations in

the disciplinary action?

A. I was tired of the medicolegal system and I was ready to stop.

Q. You previously stated that you have been deposed in two to three medical malpractice suits. Were there additional medical malpractice suits against you in which you did not -- you were not deposed?

A. Yes.

Q. How many medical malpractice suits total would you estimate have been filed against you?

A. As a general surgeon, six.

Q. Were medical malpractice suits filed against you not as a general surgeon?

A. Yes.

Q. And how many were filed against you in capacities other than general surgeon?

A. Ten.

Q. In what capacities were those suits filed against you?

A. I was the defendant.

Q. In what capacity were you providing medicine in relation to those ten suits?

A. I was a cardiac surgeon.

Q. And what were the outcomes of those ten suits?

A. No depositions, never went to trial. No settlements.
Q. They were settled?
A. No settlements. They were not settled, never went to trial. No depositions.
Q. Were the lawsuits dismissed?
A. Yes, they were. All of them.
Q. And what about the six lawsuits filed against you as a general surgeon? What were the outcome of those suits?
A. Let's see. Two were settled. Well, the last two were settled -- excuse me, the last one was totally dropped.
Q. So two were settled, one was dropped. What about the other three?
A. I'd have to check my records, but they were basically nuisance suits.
Q. If they were nuisance suits, why was your accreditation to perform surgery revoked?
MR. SUTHERLAND: Object to the form. You can answer generally, if you know.
THE WITNESS: And what was the question?
BY MS. NELSON-MAJOR:
Q. If they were nuisance -- if many of these were nuisance suits, as you say, why was your

accreditation to perform surgery revoked?

A. That was internal surgery.

Q. Yes. And if several of the lawsuits were, as you say, nuisance suits, why was your accreditation in general surgery revoked?

A. The ten nuisance suits were when I was a cardiac surgeon.

Q. Okay. And the six lawsuits that were filed as --

A. A general surgeon.

Q. -- as a general surgeon --

A. Boarded as a general surgeon.

Q. Let me finish my question so you actually know what I'm asking. Out of the six --

A. Yes.

Q. Out of the six lawsuits that were filed against you as a general surgeon, you said two were settled, one was dropped. What were the outcome of the other three lawsuits filed against you as a general surgeon?

A. Again, I don't recall without checking in my records. There was no large settlement in any of them, if there was.

Q. And outside of these lawsuits, were complaints ever filed against you with the Medical

Board?

A. No.

Q. You said that you had medical licenses at some point in other jurisdictions. Were those licenses in other jurisdictions ever subject to a disciplinary action?

A. No.

Q. And the suits that were filed against you as the general surgeon, generally what were the allegations against you?

MR. SUTHERLAND: You can -- you can give very general information about the allegations.

THE WITNESS: Complications occurring during surgical procedures.

BY MS. NELSON-MAJOR:

Q. And what were the complications that were alleged to have occurred during your surgeries?

A. Anastomotic breakdowns.

Q. I'm sorry, could you repeat that again? I didn't catch the first word.

A. Anastomotic breakdowns.

Q. And what does that term mean?

A. When you put two sections of the bowel together, you create an anastomosis. Sometimes, they fall apart.

Q. And as a cardiac surgeon, what were the allegations in general of the ten lawsuits filed against you?

A. People dying.

Q. People dying?

A. Uh-huh.

Q. Were all ten of those lawsuits involving deaths of patients?

A. I suppose.

MR. SUTHERLAND: I'm going to -- yeah.

BY MS. NELSON-MAJOR:

Q. And in these lawsuits, was it alleged that you provided medical care below the prevailing standard of care?

MR. SUTHERLAND: Object to the form. You can answer.

THE WITNESS: And I apologize. The question again?

BY MS. NELSON-MAJOR:

Q. In the lawsuits filed against you, was it alleged that you provided medical care that fell below the standard of care?

A. Yes.

MS. NELSON-MAJOR: If we could take a ten-minute break, we've been going for about

another hour. Would that be okay?

And David, how much time do we have left?

THE VIDEOGRAPHER: We're at approximately 3 hours, 25 minutes.

MS. NELSON-MAJOR: Thank you.

THE VIDEOGRAPHER: We're off record at 2:50 p.m.

(Recess at 2:50 p.m. to 2:59 p.m.)

THE VIDEOGRAPHER: We are back on record. The time is 2:59 p.m.

BY MS. NELSON-MAJOR:

Q. Is accreditation something different than a Board certification?

If you're answering, Physician, you're on mute?

A. I'm not aware of all the names they have, no.

Q. When you said that your accreditation to perform general surgery had been revoked, was it revoked by a state Board of Medicine?

If you're answering, you're on mute.

A. Yes. However, the Board of Surgery revoked my Board certification and recertification.

Q. You said the Board of Surgery revoked your certification for general surgery; is that right?

A. And recertification, yes.
Q. Did the state Board of Medicine issue some other discipline against you?
A. No, other than obviously they said I could not perform any surgical procedures.
Q. What does recertification mean?
A. It means if you have kept up with the current education and you retake the Boards ten years later, see if you can pass them.
Q. Were you accredited in both general and cardiac surgery --
A. Yes.
Q. -- at one point in your career?
A. Just general.
Q. Just general? You did not hold a Board certification or accreditation in cardiac surgery?
A. No.
Q. When did you stop performing cardiac surgery?
A. 1996.
MR. SUTHERLAND: Doctor, please -- please let me have an opportunity to speak before you give your answers, all right? That way, I can object if necessary.
I'm going to object to the question and

instruct the witness not to answer and move to strike, just based on the Court's protective order.

BY MS. NELSON-MAJOR:

Q. Why did you stop performing cardiac surgery?

A. I had trouble with my back and neck.

Q. Have you ever lost admitting privileges at a hospital?

A. No.

Q. In the six suits filed against you as a general surgeon, did those patients also die?

A. No. I think only one did.

Q. And when you agreed to the revocation of your certification and recertification, did you have to stipulate to any of the allegations made against you?

MR. SUTHERLAND: I'm going to -- I'm going to object and instruct the witness not to answer the question, based on the Court's protective order.

BY MS. NELSON-MAJOR:

Q. Were your certification in general and recertification revoked based on the allegations in the six lawsuits you've mentioned?

MR. SUTHERLAND: I'm going to object. He

can generally -- I'm going to object to any specific number that you're talking about, based on the Court's protective order, and instruct the witness not to answer.

If you want to ask him something general, you can ask him.

BY MS. NELSON-MAJOR:

Q. When you agreed to the revocation of your certification and recertification, did you have to admit that your care fell below the prevailing standard of care?

A. No.

Q. Was your agreement to the revocation of your certification and recertification part of a settlement to any of the lawsuits?

MR. SUTHERLAND: I'm going to object and instruct the witness not to answer that question, based on the Court's protective order.

BY MS. NELSON-MAJOR:

Q. Were the settlements -- and again, I'm not asking for the content of the settlements. Were those settlements confidential?

A. I don't recall.

Q. Did you have to appear before the Board of Medicine in relation to this disciplinary matter?

A. Yes.
Q. Without discussing details, what was the nature of those appearances?
MR. SUTHERLAND: I think he's answered, based on your question; and so I'm going to instruct him not to answer about any specifics about appearing before a Medical Board, based on the Court's protective order.
BY MS. NELSON-MAJOR:
Q. Physician, you previously testified that there was no hearing, but you just stated that you have appeared before the Medical Board. And I'm trying to understand the difference that you're drawing there.
What were the nature of those appearances? Were you asked questions?
A. Okay, I'm confused. When you talk about medical boards, are you talking about the General Surgical Board?
Q. Was your accreditation, I believe as you referred to it, revoked by the General Surgery Board or a state Board of Medicine?
A. The General Surgery Board.
Q. When you appeared before the General Surgery Board, were you asked questions about the medical care you provided in particular cases?

A. I did not appear in front of the General Surgery Board.

Q. You appeared before the Medical Board?

A. I appeared in front of the state Medical Boards where I had my license.

Q. Was that also in connection with the disciplinary proceeding?

A. I don't recall.

Q. Were you asked questions about medical care you had provided at those appearances?

A. No.

Q. Do you recall what was discussed -- and I'm not asking right now what was discussed, but do you recall what was discussed when you appeared before the state Medical Board?

A. Basically, I think there was a discussion about why so many malpractice suits.

Q. Did you appear with counsel?

A. No. At that time, I was tired and ready to give it up.

Q. Did those meetings with the state Medical Board ever result in a disciplinary action being filed against you?

A. No, other than no surgical procedures be performed.

Q. So the direction to not perform surgical procedures going forward, that came from the state Medical Board, not the Board of General Surgery?

A. Correct.

Q. And did you contest that direction in any way?

A. No.

MR. SUTHERLAND: Object to the form, based on his prior answer.

BY MS. NELSON-MAJOR:

Q. When you agreed to serve as Physician for TDOC, did you inform them of any of these disciplinary proceedings against you?

A. I don't recall.

Q. Did you take any notes during the deposition today?

A. No.

Q. And do you have any documents in the room with you other than the exhibits that we've discussed?

A. No.

MS. NELSON-MAJOR: Those are all the questions I have for the Physician. Thank you, Physician, for taking the time to answer my questions.

MR. SUTHERLAND: Thank you,

Ms. Nelson-Major, Ms. Sansom, Mr. Jenkins.

THE VIDEOGRAPHER: We're off the record at 3:11 p.m.

(Proceedings adjourned at 3:11 p.m.)

C E R T I F I C A T E

STATE OF TENNESSEE

COUNTY OF KNOX

I, Rhonda S. Sansom, RPR, CRR, CRC, LCR #685, licensed court reporter in and for the State of Tennessee, do hereby certify that the above videotaped videoconference deposition of PHYSICIAN was reported by me and that the foregoing 140 pages of the transcript is a true and accurate record to the best of my knowledge, skills, and ability.

I further certify that I am not related to nor an employee of counsel or any of the parties to the action, nor am I in any way financially interested in the outcome of this action.

I further certify that I am duly licensed by the Tennessee Board of Court Reporting as a Licensed Court Reporter as evidenced by the LCR number and expiration date following my name below.

RhondaSansom@gibsonreporters.
2021.10.15 15:33:27
Signer:
CN=RhondaSansom@gibsonreporters.com

Rhonda S. Sansom, RPR, CRR, CRC
Tennessee LCR# 0685
Expiration Date: 6/30/22